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## SAN FRANCISCO MENTAL HEALTH BOARD

Gavin Newsom  
Mayor

1380 Howard Street, Suite 510  
San Francisco, CA 94103  
(415) 255-3474 fax: 255-3760  
mhb@igc.org  
www.sfgov.org/mental\_health

### MEETING OF THE MENTAL HEALTH BOARD

Wednesday, January 12, 2005  
1380 Howard, Room 537  
6:30 p.m.

DOCUMENTS DEPT

JAN -- 7 2005

### AGENDA

Public comments will be taken for each agenda item.

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### 1.0 CALL TO ORDER AND CONSENT CALENDAR (5 minutes)

For discussion and proposed action.

#### 1.1 Call to Order and Announcements from the Chair

#### 1.2 Consent Calendar

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of November 10, 2004, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the notes of the Mental Health Board Retreat of December 4, 2004 be approved as submitted.

1.2.c PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the Retreat on December 4, 2003 to the following members: Sandy Yuen, Joel Luebke

1.2.d PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of January 12, 2005, to the following members: none.

### 2.0 PRESENTATION: IMPLEMENTATION OF THE MENTAL HEALTH SERVICES ACT (Proposition 63): How will San Francisco meet all of the requirements of the act? For discussion. (50 minutes)

Dr. Robert Cabaj, Director of Community Behavioral Health Services, will provide an update on the City's plans for meeting the requirements of the Act. The Board will discuss the City's plans and its own role in the implementation process.

#### 2.1 Discussion of Possible Future Actions Related to Presentation (10 minutes)

### **3.0 DIRECTORS REPORTS (20 minutes)**

For discussion.

#### **3.1 Report from the Director of Community Behavioral Health Services**

A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

#### **3.2 Report from the Executive Director of the Mental Health Board**

A report including updates and announcements regarding the activities and operations of the Board.

### **4.0 MENTAL HEALTH BOARD COMMITTEES (25 minutes)**

For discussion and proposed action

#### **4.1 Report of the Chair of the Board and Executive Committee**

The Chair will report discussions and actions of Executive Committee. Discussion of budget policy and strategy.

##### **4.1.a Report from the Mental Health Services Act Committee**

**4.1.b PROPOSED ACTION:** Be it resolved that the Mental Health Board adopts a focus on implementation of the Mental Health Services Act for its goal for 2005: (Attachment A)

**4.1.c PROPOSED ACTION:** Be it resolved that the Mental Health Board endorses the NAMI Walks to be held on May 21, 2005. (Attachment B)

**4.1.d PROPOSED ACTION:** Be it resolved that the Mental Health Board will elect officers to fill vacant positions at its February Board meeting.

### **5.0 NEW BUSINESS (5 minutes)**

Suggestions for future agenda items or issues the Board might consider looking into.

### **6.0 PUBLIC COMMENT (5 minutes)**

This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

### **7.0 ADJOURNMENT**

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Donna Hall  
Sunshine Ordinance Task Force  
City Hall, Room 244  
1 Dr. Carlton B. Goodlett Place  
San Francisco, CA 94102-4689  
Telephone: (415)554-7724  
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### MENTAL HEALTH BOARD ATTACHMENT A January 12, 2005

#### PROPOSED RESOLUTION (MHB-2005-xx): MENTAL HEALTH PRIORITY FOR 2005

WHEREAS, the voters of the State of California on November 2, 2004, voted overwhelmingly in favor of Proposition 63, the Mental Health Services Act, and

WHEREAS, this Act has as its stated intention, the transformation of the mental health system in California, including the systems within each of the counties of the state, and

WHEREAS, this Act will provide in the range of \$700 million to a billion dollars statewide and \$20-50 million for San Francisco annually, and is therefore an unprecedented infusion of funding, with unprecedented opportunity for developing new programs and reaching unserved or underserved populations, and

WHEREAS, the magnitude of the changes made possible by this Act will require the active participation of advocacy and advisory groups, such as the Mental Health Board, throughout the planning and implementation phases, and

WHEREAS, under the terms of the Act, the Mental Health Board in each county is given a specific role to play in the planning for the Act, namely local Mental Health Boards are required to hold a public hearing on their county's draft plan for the implementation of the Act, and to write a report regarding the findings of that hearing, and

WHEREAS, this Act is of historic significance, now therefore

BE IT RESOLVED, that the Mental Health Board of San Francisco adopts the implementation of the Mental Health Services Act as its priority for 2005, and will deal with other issues of concern within that context, and

BE IT FURTHER RESOLVED, that the Mental Health Board of San Francisco adopts as its special mission, in concert with other advocates and advocacy organizations, to ensure that the Mental Health Services Act as implemented in San Francisco remains true to its intent, namely to transform the mental health system.







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### MENTAL HEALTH BOARD ATTACHMENT B January 12, 2005

#### PROPOSED RESOLUTION (MHB-2005-xx): ENDORSING NAMI WALKS 2005

WHEREAS, the San Francisco Bay Area chapters of the National Alliance for the Mentally Ill will be holding their first ever NAMIWalks on May 21, 2005, and

WHEREAS, the purpose of the walk is to raise \$150,000-200,000 to fund Bay Area NAMI programs which support family members and clients of the mental health system, including programs which work for improved opportunities for housing, rehabilitation and jobs, and that provide public education about mental illnesses, and

WHEREAS, these programs will be made available to everyone without charge, and

WHEREAS, the NAMIWalks event itself will help publicize the damage discrimination against the mentally-ill does, and the need to end all forms of stigma against the mentally ill, and

WHEREAS, the Mental Health Board recognizes the San Francisco Bay Area chapters of NAMI as an essential part of our local community of mental health advocates, now therefore

BE IT RESOLVED, that the Mental Health Board of San Francisco commends and thanks the San Francisco Bay Area chapters of the National Alliance for the Mentally Ill for all their work on behalf of those with mental illness and their families, and

BE IT FURTHER RESOLVED, that the Mental Health Board of San Francisco endorses the NAMIWalks which will be held on May 21, 2005.





Department of Public Health  
**SAN FRANCISCO MENTAL HEALTH BOARD**

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*Meeting*  
**MEETING NOTES**  
**Mental Health Board**  
Wednesday, January 12, 2005  
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**FEB - 4 2005**

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**BOARD MEMBERS PRESENT:** Rebecca Turner, Ph.D. (Chair); Bridgett Brown; Bob Douglas, J.D.; Joel Luebke; Toye Moses, Ph.D., M.P.H.; Dorothy Shaffer, R.N., N.P., M.S.N.; Kate Walker; Idell Wilson.

**BOARD MEMBERS ON LEAVE:** Supervisor Bevan Dufty; LaVaughn Kellum-King; Carol Knight, M.A.; chance martin; Michael Medema; Sandy Yuen.

**BOARD MEMBERS ABSENT:** Augusta Del Zotto, Ph.D., Ted Stinson.

**PRESENTERS:** Bob Cabaj, Director, Community Behavioral Health Services

**OTHERS PRESENT:** Sandra Santana-Mora (Edgewood Center); Alan V. Shipley (Client Advocate); Annamarie Hewson (Family Member); Emeric Kalman; Helynnna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

**PLEASE NOTE:** There was no quorum for this meeting. Therefore no votes were taken and no action items were decided.

**1.0 CALL TO ORDER AND CONSENT CALENDAR**

The meeting was called to order at 6:42 p.m. by Rebecca Turner, Chair.

**3.0 DIRECTORS REPORTS**

**3.1 Report from the Director of Community Behavioral Health Services**

Dr. Cabaj: Happy New Year! We're in the budget cycle. We've already had a budget cut which is going to be put in place next week. That means that clients who are indigent and not severely ill will get less care. We'll have to eliminate 6 very good staff from our clinics and we'll have to cut contract agencies by a percentage of their indigent clients. It's been a very difficult time.

Dr. Katz agreed to not stopping treatment altogether, but treatment will be limited.

But this leads unfortunately to a two-tiered system of care which is unfortunate. The press had begun to be aware of it in the fall. The decision was made on November 2nd, with the failure of a couple San Francisco propositions.

The Mayor is giving us a heads up, there is still a City deficit and a \$130 million shortfall for fiscal year 05/06. The Mayor said he'd give targets to the bigger divisions like the Department of Public Health, but we haven't gotten those targets yet.

We are also looking at structural issues, like COLAs, increases in rent, and increased costs of doing business for the City and contractors. But the Mayor said we have to absorb those in our budgets and those could be a major cost.

It could be \$8-14 million in cuts for Community Behavioral Health Services. Apparently some of the structural issues will be made clear on Tuesday at the Health Commission meeting.

We hope we will not have much in additional cuts.

We have a new system of partnership between the Police Department and the Mobile Crisis Treatment Team. Chief Heather Fong is very supportive of this. Mobile Crisis is going out and providing support to victims of violence and their family members.

Ms. Shaffer: Did you say the children's section is involved in the integration plan?

Dr. Cabaj: Yes, there have been special trainings for the children's section.

Dr. Turner: I'm wondering how the integration will affect the specific therapy methods used.

Dr. Cabaj: The first phase is getting the clinical sign off, that everyone understands that co-occurring diagnosis is the norm rather than the exception. And that everyone knows what to do no matter what issues the client has. This may mean clinical changes. It may mean onsite co-occurring treatment at sites, so people don't have to go down the street for another part of their treatment. Or it may be that the clinics will specialize as they do now, but there will be a better way of connecting people to the treatment they need. Dr. Mee Lee will be working with us on what has been proven to work.

Dr. Moses: I'm really sorry to see that we've let some of the local staff go. I'm wondering about the consultants from Zialogic, and the money we're paying them. Is their funding being affected by the budget cut?

Dr. Cabaj: No, this is one-time money that is restricted only to the work we do with the consultants.

Dr. Moses: So integration is a done deal then? Dr. Cabaj: Yes.

Ms. Shaffer: How many phases are there to integration?

Dr. Cabaj: The first phase was administrative change. We're now in the middle of the second phase, the clinical integration. But Zialogic says it takes a few years for a clinic to evaluate itself. But we want to start evaluation sooner, and get evaluation as we go.

Dr. Moses: I like the idea of identifying change agents who can lead the way with integration.

The Director's written report was distributed:

**1. FY 05-06 Budget.** Last December, Mayor Newsom issued an overview of the City's financial position and the instructions for the FY 2005-06 Budget. While the City's financial condition is improved assuming the mid-year reductions are made, a \$345 million budget deficit challenge remains over the next two fiscal years. This includes a \$130 million shortfall in FY 2005-06. City departments, including DPH, are meeting with the Mayor's Office over the next few weeks to define the financial issues for the budget year and come up with budget targets.

**2. Proposition 63 Task Force.** Mayor Newsom announced the formation of a task force, to be led by Barbara Garcia, Deputy Director, Department of Public Health, to draft the City's plan for Proposition 63 funds. The Mental Health Services Act was passed by voters in November and is expected to expand services for the mentally ill. Forty task force members from private, public, non-profits, consumers, and family members of consumers, will oversee the planning process and help determine service priorities. Mayor Newsom is looking to Proposition 63 as an opportunity to provide services towards ending chronic homelessness for individuals with multiple mental health, substance abuse, and health issues.

DPH will very soon be accepting applications from people interested in participating in the Proposition 63 task force. Please contact Edwin Batongbacal, Associate Director, CBHS, at (415) 255-3446, or email him at [edwin.batongbacal@sfdph.org](mailto:edwin.batongbacal@sfdph.org), if you are interested in being considered for the task force. An application form for task force membership will also be coming out very soon, and made widely available. The constituted task force is expected to begin meeting by late February.

**3. Police Crisis Trainings Get Good Reviews.** Since May 2001, Community Behavioral Health Services (CBHS) and the San Francisco Police Department (SFPD) have been offering the Police Crisis Intervention Training (PCIT) to police officers. The goal of this training is to educate officers about mental illness and provide them with new skills and tools to use when interacting with the mentally ill.

CBHS recently conducted a follow-up assessment of the PCIT to determine the long-term impact of this training on the officers' experiences in the field. We were interested in understanding the extent to which they used the information and skills the training provided in their contacts with the mentally ill. We sent questionnaires to all the officers who participated in one of the eight trainings offered between May 2001 and October 2003. Of the 196 officers who participated in a training, 85 completed a follow-up questionnaire (43%).

Results suggested that most officers found the training useful in the field. Skills that emerged as being especially useful include the ability to identify a person with a mental illness and to communicate with them more effectively. Many officers still expressed concern about the unpredictable nature of a mentally ill person's behavior, particularly if he or she is using drugs. Officers also said the training provided them with more information on the mental health services that are available, although they expressed frustration with the limited 24-hour services.

**4. Integration Change Agents.** Since the December 6-7 visit by ZiaLogic (our behavioral health integration consultants), almost 50 individuals from about 40 interested CBHS programs have expressed willingness to become active Change Agents in the integration effort. This month, CBHS administration intends to meet individually and separately with each of the 40 agency Program Directors, and their respective Change Agents, to begin to discuss the specifics of how the effort will unfold. In February, the Change Agents selected will begin to have monthly meetings together.

This first batch of admirable CBHS programs, and Change Agents, will use the following tools to embark on a quality improvement effort towards dual-diagnosis capability:

- a CBHS Integration Consensus Statement (which they will contribute towards developing), as the system-wide vision for the overall change effort;

- the COMPASS program self-assessment instrument, and

- a unique integration action plan that they will develop for their own individual program/agency.

CBHS central administration will support their efforts by attending to system barriers that are identified in the course of the quality improvement. Any other CBHS agencies interested in participating should contact their program monitor, or Lucy Arellano at (415) 255-3687.

The CBHS Integration Training Committee is also presenting an all day workshop, on March 8, entitled: "Integrating Services for People with Co-Occurring Substance-Related and Mental Disorders: How to Make it Really Work and Are You Ready?" The workshop will present an evidence-based integrated treatment model, which will assist in evaluating how well CBHS is serving the dually diagnosed, and in training CBHS staff across all programs to assist in planning and implementing improvements system-wide. Dr. David Mee-Lee from ZiaLogic will be the presenter. To register, mail or fax your Name/Agency/Address/Phone/E-Mail, to Junko Craft at (415) 252-3057. This training is free to all CBHS staff, but seating is limited, so register ASAP.

**5. CBHS Staff Receive Awards.** I am pleased to announce that two of our CBHS colleagues recently received awards from prestigious statewide organizations:

Albert C. Gaw, M.D., Medical Director of Quality Management of Community Behavioral Health Services and staff psychiatrist at Mission Mental Health Services,



recently received the 2004 Meritorious Service Award from the Northern California Psychiatric Society for his lifetime of distinguished service to the field of psychiatry, and in recognition of his contributions at the local, state and national level.

Sai-Ling Chan-Sew, LCSW, Director of CBHS Children, Youth & Families System-of-Care, was presented with the Children's Coordinator Award by the California Mental Health Directors Association in recognition of her exemplary work with the CMHDA Children's System-of-Care Committee, along with her outstanding and unwavering commitment to children with mental health needs, and their families.

Congratulations Albert and Sai-Ling, we are proud of you.

**6. Effective Outcomes: African-American IMD-Alternatives.** In 2002, CA Department of Mental Health funded two demonstration projects, in Merced and San Francisco counties, to examine possible best practice models for helping clients who are living in Institutions of Mental Disease (IMDs) to successfully live in the community. Both counties developed an intensive case management team that closely resembled an Assertive Community Treatment (ACT) model, delivering intensive client-focused, mental health services. San Francisco's program focused on male, African-American clients. The San Francisco team is composed of all African-American staff, and included a psychiatrist, clinician, licensed psychiatric technician, case managers, and an administrative support staff.

An evaluation funded to assess the success of these three-year programs shows that they have been highly effective at reducing total treatment costs for their clients, as a result of keeping clients out of IMDs and reducing inpatient and crisis service utilization through intensive outpatient services. San Francisco County saved over \$450,000 in treatment costs for 20 clients. Both clients and staff were also positive about the program, reporting that client needs were being met, and that clients were making progress toward recovery.

**7. Expanded HIV Services for Women at Center for Special Problems.** In April 2004, Center for Special Problems (CSP) recruited Loretta Gordon, MFT intern, to work with the HIV Mental Health Case Management Program, under Title IV federal grant funding. Loretta provides comprehensive behavioral health services for HIV-positive African American women and their affected family members. She is also out-stationed approximately 20 hours a week at Rita da Cascia in the Fillmore District in a support-residence for mothers with HIV and their children. Loretta also outreaches to clients in both the Bayview and Fillmore areas, enabling HIV positive women in those neighborhoods to have access to mental health services. Since Loretta began working at CSP, 26 additional HIV-infected women, as well as their families, have been served.

## **2.0 PRESENTATION: IMPLEMENTATION OF THE MENTAL HEALTH SERVICES ACT (Proposition 63)**

Dr. Cabaj: Proposition 63 passed on November 2nd. San Francisco was the county with the highest percentage of yes votes, at 74%.

Now we are looking at implementation. But we have had very little information come to us from the State about what we're supposed to do.

There was a press conference a few weeks ago that the Mayor called unexpectedly. He emphasized his goal, saying that he would like all Prop 63 money spent on housing, not the support services, but the housing itself. I talked to him before the press conference about the limits on this money, so he said he wanted it to go to housing as far as possible.

I've heard in other discussions, he's recognized that it's meant most likely for the support of the housing. The State called me up about the Mayor's remarks in the press conference.

There couldn't have been a better choice than Barbara Garcia to direct the implementation of Prop 63. The State said it should be the Director of Mental Health. But Barbara's been doing a lot of work on the homeless issue. She has a lot of community experience, such as setting up Proposition 36. I think it's a great appointment. And it helps relieve me of a lot of the details. But we will work together. And I am still liaison to the State as the Mental Health Director. We speak daily about this topic.

Dr. Moses: I'm really concerned. It looks like everyone is coming out with their spending list. Are there guidelines for this money? Will it all be gone with all the people who have these special requests.

Dr. Cabaj: There are lots of great ideas. But the intent of the Proposition is to open the planning process to the public to get as many great ideas as possible. I don't want to tell you what I want this money to be used for. I can tell you about gaps in the system. But I want to hear from everybody. There are things I won't think of on my own. The planning process is supposed to be driven by clients and family members.

We met with Aaron Peskin to help organize things. Fiona Ma has a focus on children. Sophie Maxwell wanted one third of the money for violence prevention which she's now learned the money can't be used for.

There are guidelines for how the money can be used.

The State wants people to think of this proposition as a series of initiatives. The first process is planning the plan. There will be funding for this process. The planning process is what Barbara Garcia will be in charge of and we'll be working on this together.

We sent out an RFQ for an outside agency to be the coordinator of the planning. That work is more than the City staff can do. And the other counties are doing this, too.

The State needs a short plan on what we are proposing to do to create the implementation plan. This would be a 5-10 page document.

The money we're most anxious about are the things that will directly affect clinical care:

- 1) The money targeted for the system of care. This is one of the most helpful things for clients, to make care seamless. The categories are youth, transitional youth, adults, transitional adults, and older adults. Fifty percent of the money will be for this pool.
- 2) Early detection and intervention or prevention. This is the first time money has been ear-marked for this. This is 20% of the money, which is a very significant amount.
- 3) 5% for innovative programs. This gives the chance for people with really new ideas to toss them out and see if they will work.

That's 80% of the money designated for good clinical care. This to meet the goals of the Act which is to transform the mental health system, to promote recovery, and to have more consumer and family member input and participation.

Those percentages are outlined for 6-7 years, then they sunset the percentages.

- 4) 10% goes toward ongoing training and workforce issues. This is not just training, but how to recruit people into the field and how to keep people in the field. This may help address the salary disparity of contractors vs. City staff.

It will also help consumers get more involved in working in behavioral health. Training peer providers so they can work in the system.

- 5) 10% ongoing issues of capital improvement and IT needs. We don't know if this is the money that can be used for buying property, or if it can only be used for upgrading current property.

Again the State hasn't given us any specific guidance on any of the above issues. They are saying probably next week, they will give guidance. They will probably roll out guidelines one area at a time. And it may take till May before we get them all.

They want us to give them our plan by the end of June so they can review it at the State level and we can start spending the money. The dollars won't be available until October, but then if your plan is not approved once the money starts, then you will lose money. So we want our plan reviewed and approved in time for the release of the money.

So you can see that there are a lot of steps to take and very little time. This planning process is going to be challenging.

There will be a forty member steering committee guiding this process. There will be a series of sub-committee meetings. They will probably be co-chaired by a City person and a community person. Perhaps there will 6-8 committees.

Dr. Turner: Is it too early to contact Edwin if people are interested in serving on the Task Force?

Dr. Cabaj: People can contact Edwin Batongbacal at 255-3400. No one is being selected yet. Everyone wants to be represented—unions, politicians, etc.

All of the meetings will be open to the public in publicly accessible places. Some of the planning money is to be used to help people attend the meetings in terms of things like child care.

Ms. Brooke: It would seem helpful if an MHB member were on that steering committee, since the MHB has to hold a hearing. We've been talking about holding our MHB hearing in City Hall and televising it. Could the planning money be used to televise this?

Dr. Cabaj: I think the money would cover that. We're thinking about things like having meetings in each of the eleven districts to make sure we are being accessible.

We want to use what we learned from the implementation of Prop 36. And we look forward to guidance from the State on getting the broadest input. I don't think the State is withholding. They were told they could do no planning before November 2nd, because that would look like they were biased in favor of Prop 63. So once the proposition was passed, they suddenly had to start planning. They've now hired 36 people to work with them.

Of the initial money, 45% could go to capital improvements and IT. Our county is about the same as a tin can and string when it comes to information technology. We have no clinical records that are electronic, and no way of sharing information easily with the confidentiality that we need in the electronic age. Our billing suffers because of this, which makes the system lose money.

Every county is facing that. Behavioral health financing and billing is a world into itself. So no company has ever focused on this. Five companies are now working on this.

I am the Chair of the local Behavioral Health Directors, and no county ranked their needs the same way as any other county.

We don't know how much money we're going to get. The State hasn't decided on a formula yet. It's supposed to be based on unmet need. But they don't know how they're going to measure it yet. They are talking about looking at the census of people at 200% of poverty level who have not received services.

But that has problems, and doesn't take into account our homeless population. It does not take into account that San Francisco is a magnet for people with behavioral health problems. We have a disproportionate population here. And then there is the undocumented population. Leland Yee is quite concerned about this.

Ms. Shaffer: Are we going to have access to these ideas brought forth in the planning? Some of them could be implemented now. What are you going to do with those ideas?

Dr. Cabaj: We're going to try to figure out what is our unmet need. That's one place we'll need input. We want to educate people about what we have now. Many of the

ideas so far are more general ideas. Any ideas we get will be made publicly available. The State wants everything written and documented about the ideas people bring forward.

There are going to be a lot of ideas. But no matter how much money we get, we won't be able to do everything, but we will have to prioritize. We'll need an overarching set of priorities.

Dr. Moses: I want to implore you to continue to advocate for us. We don't want all the money to go into paperwork. We want to make sure this goes to treatment. We want to make sure clients are able to articulate their concerns. We want to make sure some of our MHB members are represented in the process. I was at the Mayor's State of the City address. The Mayor said he is looking for new money. We want to keep an eye on this new money, too.

Dr. Turner: Aaron Peskin emphasized in a meeting with Bob Douglas and myself this morning, the role of consumer input, and that the MHB needs to make sure to leverage consumer involvement.

Mr. Douglas: The Mayor's Office on Disability has a telephone set up so people can call in to their meetings and make comments. It would be a great thing if we could use that. I don't know how expensive that is.

Dr. Cabaj: That's great. We're consulting with the Office of Disability regarding the application forms for the steering committee and other committees.

Dr. Turner: The Mayor's Office has said there will be the ability for people to be on line. It would be nice to have something like that. Some people may write what they won't say. When we had the consumer focus group recently, some people said some clients might not speak in a group, but want to give input in other ways.

Ms. Hewson: I think the first priority should be the treatment of the mentally ill. There is no education whatsoever about medication and that is a big problem. There should be some research done about the effect of the medication that is given. And it should not be done by the pharmaceutical industry. What these days we are forgetting is psychotherapy. There should be training for effective psychotherapy for the mentally ill.

Member of the public: I'd like to see a less standardized form of psychotherapy. As a victim of child abuse, I went to New Leaf and they ended up abusing me. They had these standardized questions. I had no time to talk about my issues. The therapist's hands were tied. He didn't have flexibility.

I don't have suicidal tendencies. I'm a depressed person, but not suicidal. And it really upset me to keep being asked about suicide. I just started ASCA, Adult Survivors of Child Abuse. I don't handle authoritarianism very well. Access knew that about me. But they stuck me with someone who was another standardized authoritarian clinician. Unfortunately you don't have alternative therapies.



When I tell them to stop asking me those questions, they should stop. I'm not suicidal. I'm not homicidal. I wanted to talk about my child abuse history so I can get back to work. I'd like to see alternatives like co-counseling.

Mr. Casados: Two things. I'm concerned that the MHB is only asking for one seat on the 40-member steering committee for Prop 63. I think that the MHB should get 2-3 seats. You said 10% of the seats would be for clients. That would be four seats. I think the focus of this bill is for clients, and so there should be more seats for clients.

Mr. Shipley: I'm an active client advocate. There is an organization statewide made up of members of mental health boards and commissions from around the state. It's called the California Association of Local Mental Health Boards/Commissions. You can take issues from your local mental health boards and share them with all the MHBs.

My concern is very similar to Benito's. I'm closely associated with the Cal Network of Mental Health Clients, which was the main client organization that helped put together Prop 63. Our language is in that proposition and it calls for more than 10% for consumer services, recovery centers, self help centers, and new services for consumers. It's not just 10%. That's a very low percentage of the money.

I'm going to the consumer forum this weekend. And I would like to bring some of that back to the Mental Health Board. One reason this proposition was written is that the clients have been left out for 30 years. We want to move in and help influence and change the system for beneficial purposes.

Dr. Turner: It's very interesting that Prop 63 is being done at that same time as integration. Dr. Cabaj: I'm happy that the two are coinciding. That will make the system stronger.

Mr. Luebke: Does Prop 63 provide for any funding for basic research?

Dr. Cabaj: Not technically, unless that's perhaps included in education. But they do want us to use evidence-based programs.

Dr. Turner: I can't imagine that Prop 63 would be used for research because there are so many other sources for research funding.

Dr. Cabaj: There's a lot of good research on prevention and early intervention. So why not apply that? We'll be able to use research in a way that we haven't before.

Mr. Kalman: When do they expect the first dollar to go into the special account?

Dr. Cabaj: They expect the first dollars for the clinical side to flow in October.

Dr. Moses: Can you respond to this gentleman about looking into his concerns about New Leaf?

Dr. Cabaj: We've heard concerns about that program before and we are working with them, and if they don't lighten up, there may be consequences. If I hear that there is a



program that is not consumer friendly or if I see a large drop-out rate, then I want to look at those programs closely.

Member of the public: I just want people to know that when you are dealing with child abuse, having the authoritarian approach really hurt me. I submitted a grievance, but it's been three months and it's not resolved.

Dr. Turner: We'd like to hear follow up from you. Member of the public: Thank you.

#### **4.0 MENTAL HEALTH BOARD COMMITTEES**

##### **4.1 Report of the Chair of the Board and the Executive Committee.**

Dr. Turner: There are no actions to report from the committee. The Board has had an amazingly busy month.

Congratulations to Dr. Moses on being elected to the California State Democratic Central Committee.

Ms. Walker: Thanks for sending me to the stakeholder meeting in Sacramento. One of the things that stuck me the most is that the Mental Health Director should be in charge of the implementation of Prop 63, and I come back here and see the public health administrator in charge instead. And I see the Mayor's press conference which seemed to be contradictory to the Proposition.

The people who were running the meeting in Sacramento seemed to have in mind that they would not put up with people changing Prop 63. The meetings were very open, everyone got to say their piece.

I also met with Supervisor Sean Elsbernd. He's very busy and very sharp. He asked a few questions and got a good idea of me. I was very impressed with him.

Dr. Turner: Michael Medema and I attended a budget meeting with Barbara Garcia. I was impressed with how many questions Michael asked. Providers were saying, we can't keep delivering the same services with these cuts. People were very distressed. I can't say anything good about it, except people are doing the best they can.

I went to Sacramento in January and was able to meet with Darryl Steinberg, Stephen Mayberg, and Rusty Selix. Dr. Cabaj covered most of what they talked about at the meeting. But I think that collaboration is the key, and doing things differently. The broad stakeholder input is so important. It's important for the MHB to be very active. The Corporation for Supportive Housing talked about the role they can play in leveraging money for housing that has the connection with support services.

Mr. Douglas: Becky and I met with Supervisor Peskin. I was a little nervous. He's one of most powerful people in City now that he is President of the Board of Supervisors. But he turned out to be another human being. He is in our corner. His parents were both mental health professionals. His message was that we as the Mental Health Board should be more in their face. He gave us the time we really needed.

Dr. Turner: We asked him about the role of the Board of Supervisors. He said the Mayor proposes and the Board of Supervisors disposes. He said he'd like this to be a collaborative process regarding Proposition 63 and to assure that what we submit to the State are very well thought out approvable plans.

Dr. Turner: We want to honor Bridgett Brown since this is her last meeting as a member of the Mental Health Board. She has been on the Board for five years.

Dr. Turner: The MHB's Prop 63 Committee met on December 14th. We agreed to have priorities. We decided to have three committees and get our committee system back in place: 1) Executive Committee (including running the Prop 63 hearing), 2) Stakeholders Committee, and 3) Budget Committee (which meets quarterly).

## **5.0 NEW BUSINESS**

Mr. Luebke: At the MHB Retreat we talked about doing some brainstorming about building our board membership.

Ms. Walker: Should members of the TOD be considered?

Mr. Douglas: Are we still thinking about moving our meetings to City Hall?

Dr. Turner: Michael Medema is following up on that with Bevan Duffy's office. He's going to be looking at meeting rooms.

Dr. Moses: I think that would be a good idea to meet in City Hall.

Ms. Walker: We might consider changing the date of the meeting so Bob Cabaj can come to every meeting.

Dr. Moses: I don't know what we can do about members not showing up and not having a quorum. We need to convey to Bevan Duffy the importance of having someone here to represent him.

Dr. Turner: I find it very disappointing not to have a quorum.

Ms. Brooke: The State auditors said some boards have a policy that a member can only miss 4 meetings, no matter what the reason, whether they are sick or have another engagement, and then they're automatically off the board. We've been more lax.

Mr. Luebke: Being more lax makes it difficult to get someone off when they are not attending. That plan of a maximum of four absences makes it less awkward.

## **6.0 PUBLIC COMMENT**

Mr. Kalman: Regarding changing the meeting time, Wednesday is one of the best days. We could talk with Dr. Cabaj to see if he can change his meeting.

## **7.0 ADJOURNMENT**

There being no further business, the meeting was adjourned at 8:35 p.m.



# SAN FRANCISCO MENTAL HEALTH BOARD

Gavin Newsom  
Mayor

1380 Howard Street, Suite 510  
San Francisco, CA 94103  
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www.sfgov.org/mental\_health

## MEETING OF THE MENTAL HEALTH BOARD

Wednesday, February 9, 2005  
1380 Howard, Room 537  
6:30 p.m.

DOCUMENTS DEPT.

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### AGENDA

Public comments will be taken for each agenda item.

#### 1.0 CALL TO ORDER AND CONSENT CALENDAR (5 minutes)

For discussion and proposed action.

02-01-05 10:00 AM

##### 1.1 Call to Order and Announcements from the Chair

##### 1.2 Consent Calendar

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of November 10, 2004, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the notes of the Mental Health Board Retreat of December 4, 2004 be approved as submitted.

1.2.c PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the Retreat on December 4, 2003 to the following members: Sandy Yuen, Joel Luebke

1.2.d PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of January 12, 2005, to the following members: Sandy Yuen, chance martin, LaVaughn Kellum-King, Michael Medema

1.2.e PROPOSED ACTION: Be it resolved that the notes of the Mental Health Board meeting of January 12, 2005 be approved as submitted.

1.2.f PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of February 9, 2005, to the following members:

#### 2.0 PRESENTATION: JAIL HEALTH SERVICES

(50 minutes)

Mental Illness in the San Francisco jail and the services provided for the inmates.

##### 2.1 Discussion of Possible Future Actions Related to Presentation

(10 minutes)

#### 3.0 DIRECTORS REPORTS (20 minutes)

For discussion.

3.1 Report from the Director of Community Behavioral Health Services  
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board  
A report including updates and announcements regarding the activities and operations of the Board.

#### **4.0 MENTAL HEALTH BOARD COMMITTEES ( 15 minutes)**

For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee  
The Chair will report discussions and actions of Executive Committee.  
Discussion of budget policy and strategy.

4.1.a Report from the Board Members on meetings and conferences attended.

4.1.b PROPOSED ACTION: Be it resolved that the Mental Health Board adopts a focus on implementation of the Mental Health Services Act for its goal for 2005: (Attachment A)

4.1.c PROPOSED ACTION: Be it resolved that the Mental Health Board endorses the NAMIWalks to be held on May 21, 2005. (Attachment B)

#### **5.0 ELECTION OF OFFICERS**

(10 minutes)

The Board will elect officers to fill vacant positions of Vice Chair and Secretary.

#### **6.0 NEW BUSINESS (5 minutes)**

Suggestions for future agenda items or issues the Board might consider looking into.

#### **7.0 PUBLIC COMMENT (5 minutes)**

This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

#### **8.0 ADJOURNMENT**

##### **DISABILITY ACCESS**

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD). Five days notice before the meeting will help to ensure the presence of an ASL interpreter or sound enhancement system. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station.

Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and 14 Mission. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley which runs on the opposite side of the building from 10th Street.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

#### **POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES**

The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

#### **KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE**

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Donna Hall  
Sunshine Ordinance Task Force  
City Hall, Room 244  
1 Dr. Carlton B. Goodlett Place  
San Francisco, CA 94102-4689  
Telephone: (415)554-7724  
Fax: 4(15) 554-5163  
E-mail: Donna\_Hall@ci.sf.ca.us

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from Ms. Hall, or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: [www.sfgov.org/sunshine.htm](http://www.sfgov.org/sunshine.htm)

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: [www.sfgov.org/mental\\_health](http://www.sfgov.org/mental_health). You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

**Lobbyist Registration and Reporting Requirements**

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site [www.sfgov.org/ethics](http://www.sfgov.org/ethics).





## SAN FRANCISCO MENTAL HEALTH BOARD

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### MENTAL HEALTH BOARD ATTACHMENT A February 9, 2005

#### PROPOSED RESOLUTION (MHB-2005-xx): MENTAL HEALTH PRIORITY FOR 2005

WHEREAS, the voters of the State of California on November 2, 2004, voted overwhelmingly in favor of Proposition 63, the Mental Health Services Act, and

WHEREAS, this Act has as its stated intention, the transformation of the mental health system in California, including the systems within each of the counties of the state, and

WHEREAS, this Act will provide in the range of \$700 million to a billion dollars statewide and \$20-50 million for San Francisco annually, and is therefore an unprecedented infusion of funding, with unprecedented opportunity for developing new programs and reaching unserved or underserved populations, and

WHEREAS, the magnitude of the changes made possible by this Act will require the active participation of advocacy and advisory groups, such as the Mental Health Board, throughout the planning and implementation phases, and

WHEREAS, under the terms of the Act, the Mental Health Board in each county is given a specific role to play in the planning for the Act, namely local Mental Health Boards are required to hold a public hearing on their county's draft plan for the implementation of the Act, and to write a report regarding the findings of that hearing, and

WHEREAS, this Act is of historic significance, now therefore

BE IT RESOLVED, that the Mental Health Board of San Francisco adopts the implementation of the Mental Health Services Act as its priority for 2005, and will deal with other issues of concern within that context, and

BE IT FURTHER RESOLVED, that the Mental Health Board of San Francisco adopts as its special mission, in concert with other advocates and advocacy organizations, to ensure that the Mental Health Services Act as implemented in San Francisco remains true to its intent, namely to transform the mental health system.





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### MENTAL HEALTH BOARD ATTACHMENT B February 9, 2005

#### PROPOSED RESOLUTION (MHB-2005-xx): ENDORSING NAMI WALKS 2005

WHEREAS, the San Francisco Bay Area chapters of the National Alliance for the Mentally Ill will be holding their first ever NAMIWalks on May 21, 2005, and

WHEREAS, the purpose of the walk is to raise \$150,000-200,000 to fund Bay Area NAMI programs which support family members and clients of the mental health system, including programs which work for improved opportunities for housing, rehabilitation and jobs, and that provide public education about mental illnesses, and

WHEREAS, these programs will be made available to everyone without charge, and

WHEREAS, the NAMIWalks event itself will help publicize the damage discrimination against the mentally-ill does, and the need to end all forms of stigma against the mentally ill, and

WHEREAS, the Mental Health Board recognizes the San Francisco Bay Area chapters of NAMI as an essential part of our local community of mental health advocates, now therefore

BE IT RESOLVED, that the Mental Health Board of San Francisco commends and thanks the San Francisco Bay Area chapters of the National Alliance for the Mentally Ill for all their work on behalf of those with mental illness and their families, and

BE IT FURTHER RESOLVED, that the Mental Health Board of San Francisco endorses the NAMIWalks which will be held on May 21, 2005.



# Help Improve the Mental Health System!

The Mental Health Board is looking for new members.

Minorities are especially welcome to apply.

## *Current Openings*

### CONSUMER SEAT

People who are clients or former clients of a public mental health system.

### FAMILY MEMBER SEAT

Relatives, spouses, or partners of a current or former client of a public mental health system.

### PUBLIC INTEREST SEAT

Anyone with an interest in public mental health services.

## *Future Openings*

### MENTAL HEALTH PROFESSIONAL SEAT

Nurse, therapist, psychologist, psychiatrist, or administrator

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As a Board member you would:

1. Attend the Board meeting on the second Wednesday evening of each month, from 6:30 to 8:30 p.m., at 1380 Howard Street, 5th Floor.
2. Serve on a committee of the Board and attend committee meetings one evening a month for 2 hours.
3. Participate at least one program review each year.
4. Attend the Annual Retreat, usually on a Saturday in early December.

Mental Health Board members are appointed by the Board of Supervisors. To be considered for an opening you have to be a resident of San Francisco, a citizen of the United States, 18 or older, and you can't be working for the mental health system.

If you are at all interested in this, please don't be shy about calling Helynnna or Rich at the Mental Health Board office. They welcome your questions and are glad to talk with you. You don't have to have lots of policy experience to be a valuable member. What matters is that you care deeply about making sure that the best possible services get to everyone who needs them. New members get lots of support from our veteran members and our staff. And you get to know a lot of great people!





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### MEETING NOTES

#### Mental Health Board

Wednesday, February 9, 2005  
1380 Howard Street, Room 537  
San Francisco, CA 94103  
6:30 p.m.

### DOCUMENTS DEPT.

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**NOTE: There was no quorum for this meeting, therefore no votes were taken.**

**BOARD MEMBERS PRESENT:** Rebecca Turner, Ph.D. (Chair); LaVaughn Kellum-King; chance martin; Michael Medema; Dorothy Shaffer, R.N., N.P., M.S.N.; Kate Walker; Idell Wilson.

**BOARD MEMBERS ON LEAVE:** Bob Douglas, J.D.; Supervisor Bevan Duffy; Carol Knight, M.A.; Toye Moses, Ph.D., M.P.H.; Joel Luebke; Sandy Yuen.

#### **BOARD MEMBERS ABSENT: PRESENTERS:**

**OTHERS PRESENT:** Bill McConnell (Director of Quality Management, Community Behavioral Health Services); Benito Casados; David Pilpel; Emeric Kalman; Annemarie Hewson; Mickey Shipley (Conard House, San Francisco Network of Mental Health Clients, CBHS Client Council); Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

#### **1.0 CALL TO ORDER AND CONSENT CALENDAR**

The meeting was called to order at 6:32 p.m. by Rebecca Turner, Chair.

#### **2.0 PRESENTATION: JAIL HEALTH SERVICES**

The speaker called in sick, so there was no presentation.

#### **3.0 DIRECTORS REPORTS**

##### **3.1. Report from the Director of Community Behavioral Health Services**

Dr. McConnell distributed the Director's written report:

**1. FY 05-06 Budget.** The Mayor's Office has given Department of Public Health a General Fund reduction target of \$13 million for FY 05-06, which is roughly half of the original projected departmental shortfall. In addition, DPH been asked to propose an additional \$10 million in contingency reductions.



CBHS' share in the targeted DPH General Fund reductions for FY 05-06 is \$4 million in baseline reductions (\$1 million from mental health, and \$3 million from substance abuse services), and an additional \$4 million in contingency reductions (\$2 million each from mental health and substance abuse services). These 05-06 reductions are on top of the mid-year cuts this FY 04-05. The Health Commission will hear the first round of budget proposals at its next regularly scheduled meeting on February 15.

**2. Proposition 63 Planning Preparations.** Applications are being accepted for membership to the 40-member Mental Health Services Act (MHSA) (Proposition 63) planning task force, from interested persons who feel they possess essential expertise, representation and/or experience. Consumers of mental health services, and family members of consumers, are especially encouraged to apply for membership to this 40-member task force. DPH will ensure equitable representation of all stakeholders on the task force.

An application form is available online at: <http://www.sfdph.org/Prop63/default.htm>.

The deadline for submission of applications is Tuesday, February 22 - applications must be received by close of business (5:00 PM) on that day.

The 40-member planning task force will assist the county in developing a meaningful 3-year plan to be proposed to the California Department of Mental Health (DMH) on how MHSA funds will be spent in San Francisco. Mayor Gavin Newsom has appointed Deputy Director of Health, Barbara Garcia, to lead this citywide task force in an inclusive, deliberative, and extensive planning effort. Meetings of the planning task force will be open to the public, with time allocated for public input, and will rotate locations through different neighborhoods of the city. Planning sub-committees will also be constituted (which will be open to everyone for direct participation) to assist the task force in the details of the planning for certain key sub-areas, including: children, youth and families services; transitional-age youth services; adult services; older adult services; mentally-ill offender/criminal justice-related services; homeless services; early intervention/prevention; vocational and self-help services; and education/training/human resources. A draft 3-year plan is required to undergo a 30-day review period, and then a public hearing sponsored by Mental Health Board.

#### Final plans

for the use of MHSA funds for services to seriously mentally-ill adults/older adults and seriously emotionally-disturbed children & youth can be submitted by counties to DMH as early as July 1, 2005, and moneys for services will start to be become available by October 2005.

The selected members of the San Francisco MHSA planning task force will be introduced in a kick-off meeting on Wednesday, March 2, 4:00 - 6:00 PM, at the Green Room of the War Memorial Building, 401 Van Ness Ave. DMH Director Steve Mayberg, M.D.; Rusty Selix, Director of the California Mental Health Association; and Darrell Steinberg, former California Assembly-member and principal sponsor of Proposition 63, will be at the March 2 gathering to explain the vision and objectives of the Mental Health Services Act.

**3. Behavioral Health Integration Training for Psychiatrists, Nurse Practitioners, and Pharmacists.** CBHS is holding a training, directed mainly to psychiatrists, nurse practitioners, and pharmacists, entitled: "Evaluation and Treatment Planning of Co-Morbid Psychiatric Conditions." This training will be conducted by Drs. Chris Cline and Ken Minkoff of ZiaLogic as part of their next quarterly consultation visit to San Francisco in late March. The workshop will address the medico-psychiatric aspects of dual-diagnosed clients, focusing on evaluation and treatment planning. The training will be held from 1:00 ñ 3:00 PM, on Thursday, March 24, at the DPH Auditorium, 101 Grove, 3rd floor. To register, fax or mail your Name/Agency/Address/Phone/E-Mail, to Junko Craft at fax (415) 252-3057, or 1380 Howard St., 5th floor, San Francisco, CA 94103. This training is free to all CBHS and DPH contract and civil service staff, but seating is limited, so register ASAP. CME credits will be offered.

**4. NAMI Family Support Meeting.** A group for family members and friends of the mentally ill has started to meet regularly in San Francisco. The group provides peer support, education about mental illness, and information regarding community resources. It meets every Tuesday, from 5:15 pm to 6:45 pm, at San Francisco General Hospital, 7th Floor, Room 7M30. The group is professionally facilitated by Susanne Killing, RN, MS, CNS, ANP, and Kathy Shook, RN, MS, CNS. For information about the group, please contact Susanne Killing at 415-558-5900 or just drop in.

#### **5. Other Upcoming Events:**

**PROJECT CONNECT III - HOMELESS OUTREACH** ñ The third Project Connect Outreach to the Homeless will take place on Thursday, February 17. During that day, homeless individuals in San Francisco can drop in to the Bill Graham Civic Auditorium, at 99 Grove St., where a number of City & County departments, including housing, health and human services agencies, will be available to assist them with their needs. If you want to help assist homeless individuals link up with various services on that day, please contact Judith Klain at (415) 255-3908 to volunteer. Project Connect is an initiative led by the Mayor's Office, in partnership with various City departments, as part of the vision to reduce chronic homelessness in San Francisco.

**WELLNESS-RECOVERY QUARTERLY FORUM** - On Wednesday, March 9, the Quarterly CBHS Wellness-Recovery Forum will be held from 3 - 5 PM at CBHS, 1380 Howard St., 5th floor conference room. The topic for this next quarterly meeting is: "A Meeting with Several Recovery-Oriented Programs in San Francisco." (The meetings of the Quarterly Wellness-Recovery Forum each focus on one specific topic related to the integration of the Recovery Perspective into San Francisco Community Behavioral Health Services. These quarterly forums serve:

- to support a network of Recovery enthusiasts and advocates within CBHS
- to encourage initiatives and the dissemination of the Recovery perspective as a think tank and information clearinghouse, and
- as a catalyst for change by coming up with suggestions for the System-of-Care

For more information about the Quarterly Wellness-Recovery Forum, contact Edwin Batongbacal at (415) 255-3446.)

Mr. Medema: With regard to the budget, are the numbers expected to change, given:

1) the cuts to Medicare in the federal budget by President Bush, and 2) the Controller says that revenues are up in San Francisco and there will be some extra money. Will the budget figure go up or down?

Dr. McConnell: With the federal budget, we don't know how it's going to end up. We can't predict the impact. I don't think the revenue increase will have much impact on the Department of Public Health.

Mr. Medema: What's the \$1 million baseline, what's being represented to the Health Commission on February 15th?

Dr. McConnell: We are not allowed to release the numbers until the Friday before the Health Commission meeting. So we'll be releasing them this coming Friday.

mr. martin: How will these cuts impact the single standard of care regarding indigent clients?

Dr. McConnell: We have changed that already, and I don't think we're going to change it again.

mr. martin: I'm trying to get a handle on who made the decision to abandon a key piece of public health policy the community fought for for years and make this kind of erroneous assumption that certain clusters of mental illnesses aren't as severe as others or aren't severe enough if you are medically indigent or are an immigrant. I'm baffled by who in the Department of Public Health would make such a decision.

Dr. McConnell: I think that decision came from the top of the Department of Public Health, but I imagine it's a joint decision between DPH and the Mayor's Office and the Health Commission.

mr. martin: What point is there in the community uniting to impact public health policy at the Health Commission if it's going to be abandoned? Like, what good is it to have a ballot initiative to create the Mental Health Rehabilitation Facility and then change its mission somewhere down the line. There's got to be some kind of accountability.

Dr. McConnell: Ultimately it's up to the Mayor and the Board of Supervisors.

Mr. Medema: The Friday when the budget figures are released, the Mental Health Board should have those details as well. I have a concern I'd like to have taken back to Mitch and Barbara and Bob. While this is an advisory Board, it would be good to be alerted that there are a million dollars in cuts, and have discussion with this Board before they are put on paper and handed out to people. Not that we want to have direct interaction on specific budgetary issues, but to come talk about proposed cuts in mental health services before they are released publicly.

We can meet with DPH staff between Board meetings if necessary. MHB members can attend your budget meetings. Even if it's just to sit in the back and listen to the discussion about cuts that are being proposed. We are the Mental Health Board and we

are supposed to be representing the citizens of San Francisco. It's easier to do that as part of the process rather than playing catch up.

mr. martin: We're a policy advisory body. If the Director of Public Health is going to take it upon himself to reverse board policy, we'd appreciate it if he'd let us know ahead of time.

Ms. Shaffer: Yes, I agree with that.

Dr. McConnell: With regard to Prop 63. We've hired a consultant to work with us on the planning process. There will be \$207,000 for planning.

Dr. Turner: I was wondering how many family members and how many consumers will be on the Proposition 63 Committee, out of the forty members.

Dr. McConnell: I haven't heard any numbers. They want good representation from consumers and family members.

Mr. Shipley: Just as an observation from a consumer, online there is training for family members on Proposition 63. There are no training opportunities for consumers to participate in the public process. I think that's a shame and a sham.

Mr. Medema: I actually sat in a meeting yesterday with Edwin Batongbacal and Carolyn Lieber of DPH and Belinda Lyons from the Mental Health Association and members of the Prop 63 Steering Committee who helped pass the proposition who are still actively involved. The March 2nd event is an education event for all members of the public, but with specific focus on consumers and family members.

Mr. Casados: The Department is supposed to be having a consumer meeting on February 18th at one o'clock for one hour.

Ms. Walker: I spoke to Edwin and asked him who would be making the decision about the 40 members. He asked if I wanted to meet with Barbara Garcia. But it's at the same time as the meeting for consumers in Berkeley. I think the people we would want at that meeting will be at the meeting in Berkeley on the 18th.

Mr. Medema: My understanding is that the consumer meeting on the 18th is not an open meeting. They are gathering a selected group of consumers to meet with Barbara.

Ms. Walker: This seems like such an opportunity. I began calling around and I felt I'd stumbled into something.

Mr. Medema: I sat in a meeting with Edwin yesterday. Primarily the purpose of the meeting with Barbara is to hear the concerns of consumers about the formation of the Task Force. That's the only stage we're at. All we're talking about is just the Task Force.

Dr. McConnell: We're in the process of starting work on a Quality Management structure for Barbara Garcia's division of DPH. I'm planning to restructure the quality management system for behavioral health. For right now, we've re-invigorated the

System of Care Quality Improvement Committee. I'm trying to get more family and consumer participation in that. If you are interested let me know. We can pay consumers and family members \$25 per meeting.

Mr. Medema: Can you briefly tell us what people on that committee would do?

Dr. McConnell: The State requires that we have a quality management plan. We have to have an annual work plan. One of the major things the committee does is to review the work plan. It's mainly what we're going to focus on from a quality perspective. This is an opportunity for people to bring up issues about the system that we need to look at more closely.

Mr. Medema: When do the meetings take place?

Dr. McConnell: They're held on the 4th Wednesday of the month at 10 a.m.

Ms. Shaffer: With regard to integration, most people come in through social workers. It can take years for people to get to the medical practitioners.

Ms. Hewson: I'm very concerned about medications, as part of quality management. The medications make the brain work differently from normal. I've made many complaints about the medications, but nobody could do anything about it. Sometimes one doctor is not enough. Maybe there is a need for two or three doctors. When clients are given medication, they become disabled with too much medication. So we have to look at that situation.

Dr. McConnell: We are restructuring the medical quality assurance. We're going to be getting a new medical director for CBHS, and I will talk to him about that. I know about your situation and I will talk to him about it.

Mr. Pilpel: Can Bob Cabaj report at the next meeting about the details of the \$1 million of cuts?

Mr. Casados: Where can you get the budget figures when they are released?

Dr. McConnell: They will be on the website, and you can get them from the Health Commission office.

mr. martin: I think those cuts are still a moving target.

Ms. Shaffer: When you cut the services, you are also cutting the revenue.

### **3.2 Report from the Executive Director of the Mental Health Board**

Ms. Brooke: We're actively recruiting Board members. We particularly need people of color. Three candidates for open Board seats have joined us tonight: Lisa Williams, Jojo Calubaquib, Benito Casados. Hopefully we'll have a quorum next meeting.

If you know people who are interested, ask them to call for an application and invite them to attend a board meeting so they can see if being a board member is something they want to do.

There will be a training for behavioral health staff at the Police Department on February 24th. Let me know if you want to attend.

Ms. Wilson: I attended the last training and it was like being trained to be a police officer. You do simulations of driving the police cars, and do simulations of typical situations police officers face. They told us some stories that are not usually told about what police officers go through and how dangerous their job can be. It's a really good training.

Ms. Brooke: We need to do five program reviews by the end of June. Please let me know what programs you'd like to visit.

Ms. Walker: Is there anything that anybody here would like to tell Barbara Garcia or to ask her? I'll go to the meeting on the 18th. I would like to make the meeting more valuable for us.

mr. martin: Just one comment I'd love to make about all this, having seen what new mental health dollars are like. I hope this doesn't turn into one of those blood in the waters situation.

Ms. Wilson: That's already happening.

Mr. Medema: That started happening the day after the measure passed.

mr. martin: We need to come to some kind of consensus about what kind of core services we need to sustain and grow. We certainly have a lot of pointers, as far as identifying underserved populations and communities. We'd better have our ducks in a row. It's going to be a real interesting time.

#### **4.0 MENTAL HEALTH BOARD COMMITTEES**

Dr. Turner: On the first of February, at the Health Commission meeting, Bob Cabaj and Barbara Garcia presented the plan for the planning for the Prop 63 Task Force and the time line. Those PowerPoint slides are on the DPH website at [www.sfdph.org](http://www.sfdph.org), and Helynna can forward them to you. That's the best information to date.

The Health Commission was very happy about this funding and how it can change mental health services in the City. They asked about the MHB and the hearing we'll be holding at the end of the planning process.

The Mental Health Association presented testimony, saying, We've enjoyed this collaboration with DPH so far, but we're going to continue monitoring the process.

The MHA and the Prop 63 Steering Committee share many of the concerns the MHB has. They want very broad stakeholder support.



I made a presentation to the Health Commission, saying that we were pleased to be in the process, and that we are taking our role the hearing and the written report very seriously. I spoke with Barbara Garcia, and she said she wants us very involved in the process. I will meet with her on February 24th to hear what her plans are. I've already talked with Supervisor Bevan Dufty about this, to let him know we are preparing for our role. It's critical that there is a fair and transparent process, with fair representation. It's in all of our interests that the process goes well so people feel good about the plan and as a result the state gets that message and the City gets the money as soon as possible.

Dr. Turner: Now I'd like to ask other Board members what meetings you've been to.

Mr. Medema: I went to the planning meeting for the March 2nd event. It's being organized by the MHA and the Prop 63 Campaign Committee. The MHB will co-sponsor it and it will be hosted by DPH in the Green Room at 401 Van Ness. The focus is on educating the public about the purposes of the Proposition. Belinda will open the event. Becky will talk about the MHB. Then Darrell Steinberg, Stephen Mayberg, Sally Zinman, and Rusty Selix will speak.

We're expecting that Barbara and Bob will present the 40-member task force. It sounds like this will be a great event to come to to learn about Prop 63.

I passed out an article tonight from the *Examiner*. This is not entirely new news, but the fact that suicide outpaces homicides in San Francisco is significant. Becky and I had a meeting earlier today with Supervisor Bevan Dufty and gave him that article and suggested the Board of Supervisors might want to follow up on this.

Ms. Shaffer: I attended the Parent Convention of the San Francisco Unified School District. I talked with the director of the truancy section and he said the mental health component is one of the most challenging parts of getting kids back into school. He's having a heck of a time collaborating with mental health services in getting help for these kids. I talked about the Mental Health Board in all the workshops I went to and with the presenters I talked with.

Ms. Kellum-King: I attended the NAMI Steering Committee meeting for the NAMIWalk on May 21. Our Supervisor, Bevan Dufty, has already signed on as one of the endorsers.

Ms. Brooke: We've handed out flyers for the new Golden Gate Psychological Health Center, which is sliding scale, and which offers treatment without the use of medications.

## **5.0 ELECTION OF OFFICERS**

Since there was no quorum, the election could not be held.

## **6.0 NEW BUSINESS**

Mr. Medema: It would be good to have some people from DPH come and talk about suicide and this statistic in the *Examiner* and what's being done to change this statistic.



Ms. Shaffer: And include line staff.

Ms. Kellum-King: Such as Suicide Prevention staff.

Ms. Shaffer: We could talk with Keith Chow about the issue of truancy and mental health.

mr. martin: I think we ought to absolutely talk about the single standard of care, and calendar it so we talk about it before the Board of Supervisors talk about it. There are several community-based providers who are being adversely impacted by these decisions.

They are going to disallow services for adjustment disorders, mood disorders and anxiety disorders. This is being done with no severity assessment. If your diagnosis is in that cluster you are just out of luck. These are really common diagnoses.

Ms. Walker: I'd like to have a discussion of just how we get new members and what we can do to keep them.

## **7.0 PUBLIC COMMENT**

Mr. Shipley: About the presentation on suicide, Eve Meyer, Director of Suicide Prevention, has a world of knowledge and is a great presenter. I was at the Health Commission meeting two weeks ago where Mitch Katz presented his budget. One of the proposals was to cut services to indigent populations where they can't get reimbursements. I'm very concerned about that because I work at the Spiritmenders drop-in center. We work with the indigent population who come down there and complain and act out, and because they are not receiving services, not receiving medication, not receiving any kind of outreach by the system. Another concern is Project Connect, that it's going to be at one place, instead of out on the street where people are. And most people will not come somewhere, you have to go to them. I'm sure some people on this Board understand it.

There are people outside the mental health system who want to stay outside the system. They do not want to be part of the bureaucratic system. They need outreach services, as in New York City and other places around the country.

Mr. Pilpel: The annual Ethics and Sunshine Training will be held on Monday, March 7th, probably at the Herbst Auditorium. probably at 5:30 or 6 p.m.

Mr. Kalman: It's mandatory for Board members to attend that training.

Mr. Medema: I'm glad that everyone who is here is here tonight. And I hope we will all join Helynna in making calls to other members to get them here. We're heading into this massive piece of work with Proposition 63 and participation is really critical.

Dr. Turner: I want to echo what Michael said. Tonight one of our members is sick, Toye is in Africa, one is on a business trip, and one has a new job in Stockton. I understand that the heart of soul of those people is with the work of the Board, but we do need to have a quorum, and we do need to fill our vacancies that have come open.

I also want to say how much we appreciate the public being here, too.

Mr. Kalman: The MHB used to have committees and subcommittees. When there is an opening, you can put it in the papers, like Asian Week. Yes, we can do something more for the benefit of the community. We need to have presenters every month, someone who is well known. And have topics which are of more interest to the general public. Some months ago Bevan Dufty brought here the friend of someone who had committed suicide. We're discussing that we should bring someone here to talk about suicide. It's been in the *Chronicle* at least twice about suicides from the Golden Gate bridge. And now the street drugs are cheaper and cheaper, and the people using those drugs are ending up in the mental health system. There are many, many issues to talk about.

## 7.0 ADJOURNMENT

There being no further business, the meeting was adjourned at 7:52 p.m.



Gavin Newsom  
Mayor

## SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510  
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### MEETING OF THE MENTAL HEALTH BOARD

Wednesday, March 9, 2005  
1380 Howard, Room 537  
6:30 p.m.

DOCUMENTS DEPT.

#### AGENDA

MAR - 9 2005

Public comments will be taken for each agenda item.

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#### 1.0 CALL TO ORDER AND CONSENT CALENDAR (5 minutes)

For discussion and proposed action.

03-09-05 A09-25 RLV

##### 1.1 Call to Order and Announcements from the Chair

##### 1.2 Consent Calendar

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of November 10, 2004, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the notes of the Mental Health Board Retreat of December 4, 2004 be approved as submitted.

1.2.c PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the Retreat on December 4, 2003 to the following members: Sandy Yuen, Joel Luebkehan

1.2.d PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of January 12, 2005, to the following members: Sandy Yuen, chance martin, LaVaughn Kellum-King, Michael Medema

1.2.e PROPOSED ACTION: Be it resolved that the notes of the Mental Health Board meeting of January 12, 2005 be approved as submitted.

1.2.f PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of February 9, 2005, to the following members: Joel Luebkehan, Carol Knight, Sandy Yuen, Toye Moses, Bob Douglas

1.2.g PROPOSED ACTION: Be it resolved that the notes of the Mental Health Board meeting of February 9, 2005 be approved as submitted.

1.2.h PROPOSED ACTION: Be it resolved that the Mental Health Board grant leaves of absence for the meeting of March 9, 2005, to the following members:

## **2.0 PRESENTATION: PREVENTION AND TREATMENT ISSUES REGARDING SUICIDE** (50 minutes)

Robert Okin, San Francisco General Hospital  
John Kevin Hines, Survivor

### **2.1 Discussion of Possible Future Actions Related to Presentation** (10 minutes)

## **3.0 DIRECTORS REPORTS** (20 minutes)

For discussion.

**3.1 Report from the Director of Community Behavioral Health Services**  
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

**3.2 Report from the Executive Director of the Mental Health Board**  
A report including updates and announcements regarding the activities and operations of the Board.

## **4.0 MENTAL HEALTH BOARD COMMITTEES** (15 minutes)

For discussion and proposed action

**4.1 Report of the Chair of the Board and Executive Committee**  
The Chair will report discussions and actions of Executive Committee.  
Discussion of budget policy and strategy.

**4.1.a Report from the Board Members on meetings and conferences attended.**

**4.1.b PROPOSED ACTION:** Be it resolved that the Mental Health Board adopts a focus on implementation of the Mental Health Services Act for its goal for 2005: (Attachment A)

**4.1.c PROPOSED ACTION:** Be it resolved that the Mental Health Board endorses the NAMIWalks to be held on May 21, 2005. (Attachment B)

## **5.0 ELECTION OF OFFICERS** (10 minutes)

The Board will elect officers to fill vacant positions of Vice Chair and Secretary.

## **6.0 NEW BUSINESS** (5 minutes)

Suggestions for future agenda items or issues the Board might consider looking into.

## **7.0 PUBLIC COMMENT** (5 minutes)

This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

## **8.0 ADJOURNMENT**

## **DISABILITY ACCESS**

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2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and 14 Mission. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.
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The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

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Donna Hall  
Sunshine Ordinance Task Force  
City Hall, Room 244  
1 Dr. Carlton B. Goodlett Place  
San Francisco, CA 94102-4689  
Telephone: (415)554-7724  
Fax: 4(15) 554-5163  
E-mail: Donna\_Hall@ci.sf.ca.us

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from Ms. Hall, or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: [www.sfgov.org/sunshine.htm](http://www.sfgov.org/sunshine.htm)

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: [www.sfgov.org/mental\\_health](http://www.sfgov.org/mental_health). You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

### **Lobbyist Registration and Reporting Requirements**

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site [www.sfgov.org/ethics](http://www.sfgov.org/ethics).

# SAN FRANCISCO MENTAL HEALTH BOARD



Gavin Newsom  
Mayor

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## MENTAL HEALTH BOARD ATTACHMENT A March 9, 2005

### PROPOSED RESOLUTION (MHB-2005-xx): MENTAL HEALTH PRIORITY FOR 2005

WHEREAS, the voters of the State of California on November 2, 2004, voted overwhelmingly in favor of Proposition 63, the Mental Health Services Act, and

WHEREAS, this Act has as its stated intention, the transformation of the mental health system in California, including the systems within each of the counties of the state, and

WHEREAS, this Act will provide in the range of \$700 million to a billion dollars statewide and \$20-50 million for San Francisco annually, and is therefore an unprecedented infusion of funding, with unprecedented opportunity for developing new programs and reaching unserved or underserved populations, and

WHEREAS, the magnitude of the changes made possible by this Act will require the active participation of advocacy and advisory groups, such as the Mental Health Board, throughout the planning and implementation phases, and

WHEREAS, under the terms of the Act, the Mental Health Board in each county is given a specific role to play in the planning for the Act, namely local Mental Health Boards are required to hold a public hearing on their county's draft plan for the implementation of the Act, and to write a report regarding the findings of that hearing, and

WHEREAS, this Act is of historic significance, now therefore

BE IT RESOLVED, that the Mental Health Board of San Francisco adopts the implementation of the Mental Health Services Act as its priority for 2005, and will deal with other issues of concern within that context, and

BE IT FURTHER RESOLVED, that the Mental Health Board of San Francisco adopts as its special mission, in concert with other advocates and advocacy organizations, to ensure that the Mental Health Services Act as implemented in San Francisco remains true to its intent, namely to transform the mental health system.





SAN FRANCISCO MENTAL HEALTH BOARD



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MENTAL HEALTH BOARD  
ATTACHMENT B  
March 9, 2005

PROPOSED RESOLUTION (MHB-2005-xx): ENDORSING NAMI WALKS 2005

WHEREAS, the San Francisco Bay Area chapters of the National Alliance for the Mentally Ill will be holding their first ever NAMIWalks on May 21, 2005, and

WHEREAS, the purpose of the walk is to raise \$150,000-200,000 to fund Bay Area NAMI programs which support family members and clients of the mental health system, including programs which work for improved opportunities for housing, rehabilitation and jobs, and that provide public education about mental illnesses, and

WHEREAS, these programs will be made available to everyone without charge, and

WHEREAS, the NAMIWalks event itself will help publicize the damage discrimination against the mentally-ill does, and the need to end all forms of stigma against the mentally ill, and

WHEREAS, the Mental Health Board recognizes the San Francisco Bay Area chapters of NAMI as an essential part of our local community of mental health advocates, now therefore

BE IT RESOLVED, that the Mental Health Board of San Francisco commends and thanks the San Francisco Bay Area chapters of the National Alliance for the Mentally Ill for all their work on behalf of those with mental illness and their families, and

BE IT FURTHER RESOLVED, that the Mental Health Board of San Francisco endorses the NAMIWalks which will be held on May 21, 2005.





## SAN FRANCISCO MENTAL HEALTH BOARD

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### UNADOPTED MINUTES

#### Mental Health Board

Wednesday, March 9, 2005  
1380 Howard Street, Room 537  
San Francisco, CA 94103  
6:30 p.m.

DOCUMENTS DEPT.

APR 12 2005

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**BOARD MEMBERS PRESENT:** Rebecca Turner, Ph.D. (Chair); Bob Douglas, J.D.; LaVaughn Kellum-King; Joel Luebkehan; chance martin; Michael Medema; Toye Moses, Ph.D., M.P.H.; Dorothy Shaffer, R.N., N.P., M.S.N.; Kate Walker; Idell Wilson.

**BOARD MEMBERS ON LEAVE:** Benito Casados, Supervisor Bevan Duffy.

**BOARD MEMBERS ABSENT:** none.

#### PRESENTERS:

Robert Okin, M.D., Chief of Psychiatry, San Francisco General Hospital  
and Professor, University of California San Francisco  
John Kevin Hines, Survivor

**OTHERS PRESENT:** David Pilpel; Emeric Kalman; Annemarie Hewson; Mickey Shipley (Conard House, San Francisco Network of Mental Health Clients, CBHS Client Council); Alexander Bingham (Golden State Psychological Health Center); Nicholas Alvarado (UCSF researcher); Carol Prell (Family Member); Sandra Degan (San Francisco Unified School District); Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

### 1.0 CALL TO ORDER AND CONSENT CALENDAR

The meeting was called to order at 6:40 p.m. by Rebecca Turner, Chair.

**1.2.a RESOLUTION (MHB-2005-01):** Be it resolved that the minutes of the Mental Health Board meeting of November 10, 2004, be approved as submitted.

**1.2.b RESOLUTION (MHB-2005-02):** Be it resolved that the notes of the Mental Health Board Retreat of December 4, 2004 be approved as submitted.

**1.2.c RESOLUTION (MHB-2005-03):** Be it resolved that the Mental Health Board grants leaves of absence for the Retreat on December 4, 2003 to the following members: Sandy Yuen, Joel Luebkehan

**1.2.d RESOLUTION (MHB-2005-04):** Be it resolved that the Mental Health Board grants leaves of absence for the meeting of January 12, 2005, to the following members: Sandy Yuen, chance martin, LaVaughn Kellum-King, Michael Medema

**1.2.e RESOLUTION (MHB-2005-05):** Be it resolved that the notes of the Mental Health Board meeting of January 12, 2005 be approved as submitted.

**1.2.f RESOLUTION (MHB-2005-06):** Be it resolved that the Mental Health Board grants leaves of absence for the meeting of February 9, 2005, to the following members: Joel Luebke, Carol Knight, Sandy Yuen, Toye Moses, Bob Douglas

**1.2.g RESOLUTION (MHB-2005-07):** Be it resolved that the notes of the Mental Health Board meeting of February 9, 2005, be approved as submitted.

**1.2.h RESOLUTION (MHB-2005-08):** Be it resolved that the Mental Health Board grant leaves of absence for the meeting of March 9, 2005, to the following members: Benito Casados.

(Passed unanimously.)

## **2.0 PRESENTATION: PREVENTION AND TREATMENT OF SUICIDE**

Dr. Okin: Thank you for inviting me. This Board is a great Board and has been really important over the years. The last time I spoke to the Board was 5-6 years ago when I did a presentation on the Crisis Resolution Team at the SFGH Emergency Room. Let me start by asking what you want to hear tonight.

Mr. Medema: There was an article in the Examiner and Chronicle recently about suicide in San Francisco outpacing homicide. While I want neither of those numbers to be high, I found that to be an alarming statistic. As we talk about new mental health services coming with Prop 63, we want to look at where we are and where we're going with regard to our response to suicide.

And, Kevin, you have a very unique perspective.

Mr. Hines: I jumped from the Golden Gate Bridge in 2000, and it's been a long, hard road to get where I am now. What I see is needed is teaching in grammar schools and high schools about suicide prevention. The numbers of suicide are making me sick even given what I did. We need some educational programs for kids. We need to speak to them about the possibilities of suicide and what to do if a family member or anyone they know is suicidal. We need to tell them who to talk to. And we need to teach parents and teachers the same information.

At my high school we had assembly meetings once a week. Suicide would be a good topic for such assemblies.

Mr. Medema: Not everyone knows your story, would you mind telling us a bit about it?

Mr. Hines: I'm bipolar, type two. In September 2000, I was 19 years old, and I was having a weekly depression every Thursday or Friday. My family life was wonderful. I

have a great family and great friends. But I was hearing voices and seeing things. I couldn't control them. I went to the bridge because I was hearing voices saying, "You must die, you must die." I hit the water and then swam to the surface. The Coast Guard picked me up. I got pneumonia. I had to have a metal plate put in my back.

Suicide prevention has become a big part of my life. I've been working on getting the barrier up at the bridge.

I had distorted ideation, and a voice telling me: "Kill yourself." When I surfaced in the water, I thought I was dreaming. I literally pinched my cheek, and realized this was not a dream. I was in terrible pain.

Like many teens, my whole thought was nobody else has this disease, nobody can help me. Who can help me with the thoughts running through my head all the time? Teens need to learn at an early age that these problems are temporary. I know you've heard this. Suicide is a permanent solution to a temporary problem. We need to teach teens that "This, too, shall pass."

And it's not just that pills are the answer. You have to do work on yourself. Teenagers don't want to hear this from an adult; it's crucial to get people my age and younger to talk with them. I hate what I did, but what I did brought me here today.

Dr. Okin: Suicide attempts are very frequent, and death by suicide is very frequent especially in some groups of the population. Even for someone like me who knows the data, it's still shocking when I look at the numbers. Suicide outnumbers homicide by 3 to 2. When you look at all the violence in this society, you wouldn't suspect that suicide outpaces homicide. During the Vietnam war, four times more people died of suicide than in battle in the war.

I'm telling you this, because it's kind of hard to wrap your mind around how big the problem is. It's because the problem is so stigmatized, and people don't want to talk about it. Kevin has a tremendous amount of courage to be doing the work he's doing.

To underscore something Kevin said, people who are depressed and people with bipolar disorder and substance abuse disorder, are at much higher risk for suicide. People with depression are 40 times more likely to die of suicide than the general population. People addicted to opiates are 15 times more likely, and people with schizophrenia are 8 times more likely.

This is a problem that clusters in certain subgroups of the population. Adolescents have a very high rate of suicide. Accidents are the first cause of death among adolescents, and then, I believe, suicide is second.

The percentage of the general population that has attempted suicide is very high. A national comorbidity study, showed that 4.6% of the population acknowledged that they had tried to kill themselves. That could be quite a range of different kinds of attempts. Women make three times as many attempts as men, but men are four times more likely to succeed in killing themselves when they do make an attempt.

Women tend to choose a way that is in many cases reversible. Whereas when men try to kill themselves, they have a much higher rate of shooting, hanging, and jumping. The choice of method makes a significant difference.

Kevin, I think it's fabulous that you've taken this tragedy and turned it into a life's work.

Dr. Moses: What kinds of resources are available for the very few who survive like Kevin?

Dr. Okin: Let's come back to prevention strategies in a few minutes, because some of them can be done without a massive expenditure of funds. But your question is what can be done for the people who survive. The good news is that most people who try to kill themselves survive it. The figure is pretty large. I can't recall the exact number just now. For each completed suicide there are ten to 25 the number of attempts which have been unsuccessful.

What that means is that even if you couldn't have prevented it before the attempt, after the attempt, you now have identified a very high risk group. So you can focus resources on these people. Most people who try to hurt themselves, one month before they try to do it, have seen a health professional. They are not totally out of contact with health care. So we need to talk about the training of doctors, because in most of those cases it was a doctor that the person saw.

Dr. Moses: First, Kevin, let me commend you for this work you are doing. Since 2000, did anyone help you to give you support?

Mr. Hines: My main support was from my father and my family. I was sent directly into a psych ward where I learned about suicide and how to prevent it. There were priests who came in to help me. I realized when I was at the psych ward, that I would never do this again. But I didn't know whether I might do something else.

I have a brother who looks up to me, I love myself now, so things are a lot different. I was going to groups, in the outpatient program at Seton Hospital. I think there need to be a lot more of such groups. I'd like to see that happen sometime in the near future. Someone who attempts suicide, needs somewhere to go. You shouldn't just be 5150'd. You need a professional to talk to who will say, "I'm your friend; I'm going to talk with you."

Mr. Medema: Kevin, you mentioned you were diagnosed as bipolar. Were you receiving therapy before?

Mr. Hines: I was on 14 pills a day the day I jumped. The psychologist I was seeing was on amphetamines himself, and he died recently from a drug overdose.

Mr. Medema: Dr. Okin, we know that so many people with depression are receiving Paxil or something from their MD, and are not receiving psychiatric treatment. Does this play any part in what we're talking about tonight?



Dr. Okin: I think the treatment is very hit and miss. If you're lucky to have a family that's involved and knowledgeable, and can face these issues, then there are places you can go to get help. But a lot of people are trying to hurt themselves in the first place because they are lonely and isolated and don't have support.

There just are never going to be enough psychiatrists for all the people who have depression. So we're going to have to figure out a way to help MDs be able to do adequate treatment of depression.

Mr. Luebke: Depression is so prevalent, when does someone cross the line and become someone who you should be concerned about in terms of suicide?

Dr. Okin: There are a few red flags. One is the presence of despair. That may seem obvious. But despair can be hidden. They may talk about it if they are asked, but people generally don't ask.

Mr. Hines: The night before I jumped, my dad asked me what was wrong. I said, "I just don't want to be here anymore." He said, "You have an obligation," because my family cared about me.

I woke up the next morning elated, because I was going to end the pain. I told Dad I was fine. He said, "Let me take you to work with me today." I said, "No, Dad, I'm fine."

He lives with that now, that feeling that I jumped because he didn't take me to a doctor. If he had been educated as to the signs of despair maybe this could have been a different outcome.

Dr. Turner: I've been reading about the suicides off the bridge in last few months. There was a high school senior in despair about work, and no signs that people picked up on. There was a 33-year-old physician on his bike, who left his helmet on the handlebars and jumped. I'm thinking about impulsivity for suicide, if that is different at different ages, and if that differentiates youth suicide from adult suicide.

Dr. Okin: That's one of the things people think is why suicide in adolescents is common, because there is an impulsivity. It's also a time when you don't really calculate that something you do is going to have a consequence.

Mr. Hines: I thought I was doing my family and friends a favor. I thought I was being selfless. If I had understood that it would hurt them more if I killed myself, that might have changed things. I just didn't get it that they would be hurt that I was gone. I just wish there was some way we could get to these kids before they start thinking like this.

If you're in 8th grade you might not want to listen to a 35-year-old man talk about suicide, but maybe you'd listen to someone do a rap about suicide, or a play.

Dr. Turner: How are you received in schools?

Mr. Hines: When I get into my story, they really listen. In the Q&A period, they start out slow, then they ask me everything, and most of the time they are really serious and they

want to know things. I've gotten six hundred letters from kids, saying I opened their eyes to a new light, or that they were suicidal, or that they stopped teasing their classmates, so they wouldn't be depressed. This education is very effective.

Ms. Walker: You should love yourself, Kevin, for helping so many people, when you didn't get the help you needed. What should Kevin's father have said?

Dr. Okin: That's a difficult question. Ms. Walker: Yes, each individual situation is so different. Dr. Okin: With hindsight, Kevin's father was able to sense that Kevin wasn't giving the full story. He tried to insist on taking Kevin to work with him. That's amazing actually. Most people wouldn't have that insight.

Certain phrases are red flags: "I don't want to be here anymore." "The world would be better off without me." "I want an end to this pain." When I hear those comments, I respond. I might be wrong, but I'd rather be overly careful.

It's so painful to think that someone you love might actually kill themselves by their own hand that you can be in denial even when it's right in front of you.

Ms. Walker: What if you come across someone in your family who is suicidal, and you say, "Don't do that to me"? Dr. Okin: It's hard to say. Many people try to kill themselves, in part because no one cares about them. So referring to yourself that way, takes the focus off the person and their suffering.

Ms. Brooke: I've raised four teenagers, and they're all very different. Teens have an upswing and down swing of moods. At what point as a parent do you insist, "I'm going take you to a therapist"? What would you suggest that parents look for and how do they work through that with the range of teens?

Dr. Okin: All a parent can really do, since they are not superhuman and cannot be omniscient, is to try to create the kind of safety in the relationship where a teenager can tell them, "I'm really suffering." The signs are usually there for a while, if there are signs at all. But sometimes there are no signs. Kevin, what would have helped you?

Mr. Hines: My dad worked a lot, and wasn't around a lot. I was at school a lot, and I felt I would shame my parents if I talked to them about this. It would have helped to have someone at school to go to and talk to. Someone to be the middle ground, the safe ground, when you can't tell mom and dad, because they birthed you.

Mr. Medema: What does this city need to do? Where do you see the state of things? Where would you like to see the state of things?

Dr. Okin: I have two responses. First, what I would emphasize is getting the press involved on a very regular basis in a variety different ways, appealing to different groups of people. We could hold the press accountable to the fact that suicide is more common than homicide and that their coverage should reflect that. We could monitor the press. In the last three months, there's been not one word about suicide in a constructive way. The same thing with the clergy. The clergy has to be responsive to the

congregation. If a group in the congregation asks for regular discussion of issues around suicide, then that can help educate lots of people.

Second, you should know what the medical school does to train physicians to identify people who are at risk and how to help them.

Mr. Luebke: What do they do?

Dr. Okin: I can't really answer that. I wish I could. But one thing the Board could do is find out. A medical student listens to a heart many, many times. How many times does a medical student get to practice with issues of depression and suicide?

Mr. Medema: We've thought of getting Mobile Crisis to operate on a 24/7 basis, and we know how horrifically difficult it is to get people into PES. We're facing another round of cuts. What do we need to do there?

Dr. Okin: I think you just never stop. This Board never stops advocating. This is a never-ending process of advocacy.

Mr. Douglas: It sounds like you're talking for the need for a full-time press person dealing with mental health. We Board members have day jobs; we're volunteers. I'm wondering as we get to Proposition 63, maybe there should be one or two staff doing this PR, going on talk shows, etc. Because Board members can't do it all the time. Maybe we need a couple of suicide educator positions, when we get this Prop 63 money.

Ms. Shaffer: Kevin, you mentioned you were diagnosed with bipolar at 16, but I'm sure you were noticing things much earlier.

Mr. Hines: My symptoms started when I was 16. I wasn't diagnosed till late in that year. My parents were getting divorced. I was on Tegritol for epilepsy, and that was masking my bipolar disorder, and the divorce devastated me. I started feeling extremely paranoid. The doctor labeled me with depression, which spiraled out of control. I was put on bipolar medications, and was back in control. But then I started going up and down like a mad man.

First, it would have helped not to have a doctor on methamphetamines. Second, it would have helped to have some kind of schooling or teaching to help me. I couldn't do it alone. I needed to know what suicide was all about.

Dr. Okin: That's really important what you said. One of the resistances to talking about suicide is the fear that you are going to stir it up. Doctors say that they don't want to plant an idea.

Mr. Hines: The word suicide needs to be replaced. It's taboo. A magazine called me because they wanted to do an article on the wacky things people have done. I told them I was appalled that they would consider what I did as wacky, and I canceled my subscription. We have to somehow erase the stigma.

Ms. Shaffer: The concern I have is that a lot of children are not diagnosed, but they have symptom after symptom. Till they get to suicide you can't get them help in this system. I see this over and over that Child Crisis says kids do not meet criteria.

Dr. Okin: The legal requirement is that the person has to be in serious danger of hurting him or herself. Sometimes the way it's interpreted it would make you think that the criteria were rigid and narrow, but they're not.

Ms. Shaffer: Yes, we have to help the health care providers and the people who are screening these children.

Dr. Okin: The Department of Psychiatry is thinking about doing a screening program in the high schools. That would help identify a percentage of kids who need help. Would that have helped you, Kevin?

Mr. Hines: Yes, absolutely.

Ms. Shaffer: Every school is supposed to have a school safety plan. But they don't always carry it out.

mr. martin: Since there is such a high incidence of suicide with people who have mood disorders, is it a good idea not to deny services to people without medical coverage, as is happening now in the Department of Public Health? Dr. Okin: Yes.

mr. martin: Would you be willing to write a letter to Dr. Katz stating that? Dr. Okin: Yes.

mr. martin: I pitch stories all day. I can imagine the response from the media will be, "We don't want to intrude on the family, as opposed to a case of homicide, where the family wants' justice. Rather than publicize suicides, I'd like to see whatever you've written.

Mr. Hines: I tried to write a book a couple years ago, and wasn't ready. But I do want to tell my stories. Dr. Okin: One possibility is to write an op-ed piece in a major paper.

mr. martin: I could be useful in terms of helping to place an op-ed piece in the papers.

Ms. Kellum-King: Thanks to both of you for being here. Kevin, you are just a divine gift. Thank you for sharing that gift. Maybe you can get a team together. It's good when children can have their peers, maybe a little older. And I've found that parents like to talk to other children, not their own, about what they can do in their own families. I teach classes to parents in NAMI and I'll give you my card.

Mr. Hines: I'd love to talk with you about getting something going.

Dr. Turner: What about cultural differences?

Dr. Okin: In some cultures the shame is so great it's very difficult to talk about suicide. And there are different ways of talking about depression. In some cultures, people say, "This is a pain deep in my heart." There is also expression through somatic symptoms.

If you are not attuned, you might miss it. Probably, there is more commonality across cultures than differences, but there are differences.

Mr. Shipley: Thank you very much Kevin for being here. I know it took a lot of gumption to be here and share your story. I heard you mention that if you had a place to go to talk to a peer it might have helped. CBHS has tried to establish mental health clinics in high schools throughout the city. We don't know how useful that would be. But if you had had a peer at your high school that you knew that you could go talk to, would that have helped?

Mr. Hines: Yes, it would have helped. I jumped when I was in college.

Mr. Shipley: If we had a team of peers to go around to colleges, high schools, and grade schools, to educate other students, and teachers, and parents, we might be able to cut the rate of suicide in half.

Mr. Alvarado: Thank you for coming, I was very touched by your story. I'm struck by how much stigma is attached to this. This is something that needs to be addressed by families and our diverse culture, including not only for suicide but other diseases like HIV. If that could be chipped away, it would be easier for people to discuss it. And then doctors might not feel they were planting the seed by talking about suicide.

Ms. Hewson: You said you were taking 14 medications, and that is what I see is a great, great problem. Medications in most cases are overprescribed. That should be part of the training of psychiatrists. That is the problem with my son at this time. He's on too many medications. It's a huge problem.

Mr. Hines: A couple of the medications I was on are now being investigated in terms of their role in suicidality.

Member of the public: Thank you. It's so great that you are sharing your story and progress. We've been focusing on preventing suicide. I'd like to roll it back to preventing people from getting to a depressive point. What goes on in a teenager's head that they think they are the only person who has ever thought a depressive thought. We need to prevent the depression, which is the medium that suicidal thoughts grow in. The mental health system is too oriented toward damage control. I love all this talk about Prop 63's orientation toward prevention. Depression is part of life, anybody can get depressed, but there is help and you can learn skills to take care of yourself. And it's true that the medications may sometimes be the problem.

Dr. Turner: Kevin and Dr. Okin, we are really fortunate to have had both of you here tonight. Thank you for your time.

### **Discussion of possible actions**

Ms. Shaffer: We need to provide information to schools and help them understand their mandates.

Mr. Luebke: I appreciated Dr. Okin's comments about medical schools. For so many of us we see our doctor for five or ten minutes and then you're out the door.

Dr. Turner: I'd like to follow up on training for physicians, because I know people involved in the development of curriculum. And perhaps at some point we might want to have them come talk with us.

Mr. Medema: I would like to ask Dr. Cabaj for his comments.

Dr. Moses: We need support programs in the system. For example, Brothers Against Guns. We need to make support systems available for people. We need to let Dr. Katz know this.

Dr. Turner: We might want to do a letter to Dr. Katz, including the issue chance raised.

Mr. Leubkeman: Along the lines of public relations, I can remember a time in my life when I did not feel a lot of worth. Someone just recognizing this and reaching out and befriending me made such a difference. We all have it in our power to reach out and connect. There was a girl who connected with me and it made such a difference to know someone cared about me.

Ms. Shaffer: I'd like to reiterate that you don't have to wait for the person to do something suicidal, but can intervene when they are having thoughts and making comments that are signs of problems.

Dr. Moses: The percentage of depression is so high, maybe we should invite the Director of UCSF Medical School to come talk with us.

Dr. Turner: Training and education is part of Prop 63 also. That might be the group to follow up on this and I think the UCSF Chair of the Department of Psychiatry is going to be on the subcommittee.

Ms. Kellum-King: I think we need teams of peers going into the schools. They could break down depression so students would know what to expect and how to knock it out, as well as who you could go to and talk to. And it would need to be a team that is diverse.

Mr. Hines: Kaiser Permanente has a team that does play all over northern California.

Ms. Shaffer: I think we need to keep inviting people from the School District. We had a student from Lowell come and talk with us about suicide and depression at that school.

### **3.0 DIRECTORS REPORTS**

#### **3.1. Report from the Director of Community Behavioral Health Services**

Dr. Cabaj: What we heard today is one of the main reasons Prop 63 originated. Not just for the money, but to change the system from a fail-first system to a help-first system. We've never had prevention and early intervention protected before. Now it is protected under Prop 63. We do fund Wellness Centers in the schools, but there is more

that needs to be done. Suicide training is integral to the training of every clinician in the city. But it's important to step in earlier.

Growing up as a gay kid, I know what it's like to feel no one wants to talk to you because you're so different. It's so important for teens to be able to talk about their issues. Education as early as possible is crucial.

With regard to the budget, we finally learned that the DPH budget will be heard on March 29, so details won't be available until the Friday before March 29th. All I know is that the Mayor was taking more time to look at ideas. Revenues are higher across the state than we thought, and it might be that we'll have fewer cuts than expected. The Mayor didn't want to have to start dealing with cuts that might not be needed. We don't know yet what the outcome will be.

The Kick-Off for Proposition 63 planning was held on March 2. It was great to see so many people sitting for so long. A friend of mine said he'd never seen an audience so willing to sit and listen. You heard that the vision is there. I just came back from Sacramento and we still don't know what the State will do, whether the money will be divided by an allocation formula or whether there will be an open pool. We directors want an allocation so we'll know what we have to work with. We'll be meeting again with Dr. Mayberg in Sacramento tomorrow.

Locally, there are three of your Board members on the planning committee for Prop 63: Idell Wilson, Becky Turner, and Michael Medema. Over two hundred people applied for positions on the 40-member committee. It was challenging to create a group of 40. The Mayor approved the list.

Dr. Turner: Can you say what will happen at the Task Force meetings? And how many people will be on the subcommittees?

Dr. Cabaj: The planning will unfold in the first meeting. We're getting help from our consultants on how the meetings will work. The task force will set priorities for subcommittees. Barbara Garcia will be the ex-officio Chair of the Task Force. I will also be at the meetings. The co-chairs of the subcommittees are all members of the Task Force. Probably there will be 1.5 hours of committee work in each meeting, followed by half an hour of public comment. Subcommittee meetings will be open to the public, with public comment.

Today the State said they were backing off on deadlines, because they are behind on their work. We're hoping that on March 15th they'll give us language on nonsupplantation. Most counties have sent in their plans. We're ahead of most counties. We want to get our final plan in as soon as we can, to get the money started flowing so we can implement new programs.

Mr. Medema: I heard about the Mayor's target budget for the big ten departments and a possible \$13 million cut for DPH.



Dr. Cabaj: I heard Monday that it was still roughly \$13 million. The Mayor was talking about cutting more from primary care rather than mental health. We've prepared two proposals, a baseline budget and then the contingency budget.

I've really tried to have the cuts not affect clinical care. But last year we had to bump up against that. And this year the cuts may impact clinical care. So we may need to have help in advocating around the budget.

The Director's written report was then distributed.

**1. Behavioral Health Innovations Task Force.** The Mayor has approved the list of 40 members to the Behavioral Health Innovations Task Force, that will assist in developing a 3-Year Plan on how Mental Health Services Act funds will be spent in San Francisco. The Task Force will hold public planning meetings every three weeks (Thursdays) from 4 ñ 6 PM, starting on April 14 and lasting until early August 2005, at rotating locations throughout the city. All stakeholders are encouraged to also attend 10 planning sub-committee meetings that will be held every 3 weeks, in between Task Force meetings. The sub-committees will be focused on the following planning sub-areas: Children, Youth and Families; Transitional-Age Youth; Adult; Older Adult; Mentally-Ill Offender/Criminal Justice; Homeless Mentally Ill; Vocational/Self-Help; Consumers; Family Members; and Early Intervention/Prevention. The schedules and locations of all planning meetings will be publicized widely as soon as they are finalized, including posted at the San Francisco MHSA/Prop 63 website at: <http://www.sfdph.org/Prop63/default.htm>. For any questions about MHSA planning, please call CBHS Associate Director Edwin Batongbacal at (415) 255-3446, or e-mail at [edwin.batongbacal@sfdph.org](mailto:edwin.batongbacal@sfdph.org).

**2. Integration Partners Poised for Action.** Over 40 Change Agents volunteering from the ranks of CBHS providers, 20-members of the CBHS Integration Advisory Committee (composed of provider staff, clients and family members), and CBHS central administration staff, are about to embark together on a change effort to improve the CBHS system towards comprehensive, continuous, and integrated services. With the help of assessment-planning tools such as COMPASS (program-level) and CO-FIT (system-level), opportunities will be identified to implement quality improvement action initiatives towards dual-diagnosis capability at CBHS programs, and towards "Any Door, the Right Door" for the system overall.

A new website on the CBHS Integration Initiative is up and running at <http://www.sfdph.org/CBHS/default.shtml>

This site contains the latest draft version of the CBHS Integration Consensus Statement. Comments/suggestions for the Statement can be e-mailed to [BHIntegration@sfdph.org](mailto:BHIntegration@sfdph.org), and the input will be incorporated into the final statement which will be completed at the end of March 2005. The new website also contains information about how to participate and contribute your talent and skills to the integration effort, such as by leading change initiatives in your program, or by participating in any of the Integration Implementation Work Committees.

Lastly, Ken and Chris of ZiaLogic are conducting their next quarterly visit with CBHS on March 24-25. They will meet with the Change Agents, the members of the Integration Advisory Committee, and the members of the Integration Implementation Committees, to discuss the next steps in actually beginning to make changes in the system. They will also do a training on "Evaluation and Treatment Planning of Co-Morbid Psychiatric Conditions" for CBHS psychiatrists, nurse practitioners, and pharmacists on Thur, Mar 24, 1-3 PM, @ DPH Auditorium, 101 Grove, 3rd floor. The workshop focuses on medico-psychiatric aspects of evaluation and treatment planning for dual-diagnosed clients. To register, fax Name/ Agency/Address/Phone/E-Mail to Junko Craft at (415) 252-3057.

**3. Peer-to-Peer Support—Going Strong in CBHS.** A total of 16 CBHS service provider program sites have partnered with the CBHS Office of Cultural Competence and Client Relations to host Peer Support Internship Programs that give Recovery-oriented opportunities for peer clients to support other clients. At present, there are 23 consumer peer-support interns working in a variety of mental health, substance abuse, dual diagnosis, and homeless services provider work-sites. The peer interns' job responsibilities include: administrative, clerical, outreach, dual recovery support, peer counseling, leadership, facilitator, receptionist, and other duties. Each consumer intern receives onsite supervision at the provider program-site. This is essential to the success of the one-year internship program. The goal of the internship program is to prepare peer-support interns for entry into permanent employment in CBHS by providing them work experience in an optimum and supportive work environments. A number of graduates from the Peer Support Internship Program are already working in permanent jobs within CBHS programs.

**4. Dr. Windham is moving on.** Charles Parker Windham, MD is leaving the Mobile Crisis Treatment Team after seven years. As Medical Director of Mobile Crisis, he provided countless hours of crisis intervention services. Dr. Windham started the Medication Linkage Service, which kept many clients from falling through the cracks after acute hospitalization. Charles provided medication and therapy for these clients until their care could be assumed in outpatient clinics. He provided supervision to psychiatric residents, and seminars on various topics to interns and staff of all disciplines throughout CBHS. He came to San Francisco on his off-hours following fires to provide psychiatric services to displaced clients. With his incomparable enthusiasm and commitment, he was the tender heart of Mobile Crisis. In a time when many people feel disconnected from health services, Dr. Windham instilled hope in clients and their families.

Charles will be greatly missed. His legacy—a style of intervention that meets clients where they are at, and respects the many individual paths to recovery. We wish him well and know that the community of Miami, Florida is very lucky to have him.

**5. In Memoriam.** I regret to announce that two of our colleagues at CBHS central administration have recently passed away: Dr. Al DeRanieri, Medical Director of CBHS Children, Youth, and Families System-of-Care, and Craig Shankel, who worked with Mental Health Access. Al and Craig will be sorely missed, and our condolences go to their families, friends, and loved ones.

### **3.2 Report from the Executive Director of the Mental Health Board**

Ms. Brooke introduced candidates for seats on the Mental Health Board who were in the audience.

### **4.0 MENTAL HEALTH BOARD COMMITTEES**

#### **RESOLUTION (MHB-2005-09): MENTAL HEALTH PRIORITY FOR 2005**

WHEREAS, the voters of the State of California on November 2, 2004, voted overwhelmingly in favor of Proposition 63, the Mental Health Services Act, and

WHEREAS, this Act has as its stated intention, the transformation of the mental health system in California, including the systems within each of the counties of the state, and

WHEREAS, this Act will provide in the range of \$700 million to a billion dollars statewide and \$20-50 million for San Francisco annually, and is therefore an unprecedented infusion of funding, with unprecedented opportunity for developing new programs and reaching unserved or underserved populations, and

WHEREAS, the magnitude of the changes made possible by this Act will require the active participation of advocacy and advisory groups, such as the Mental Health Board, throughout the planning and implementation phases, and

WHEREAS, under the terms of the Act, the Mental Health Board in each county is given a specific role to play in the planning for the Act, namely local Mental Health Boards are required to hold a public hearing on their county's draft plan for the implementation of the Act, and to write a report regarding the findings of that hearing, and

WHEREAS, this Act is of historic significance, now therefore

BE IT RESOLVED, that the Mental Health Board of San Francisco adopts the implementation of the Mental Health Services Act as its priority for 2005, and will deal with other issues of concern within that context, and

BE IT FURTHER RESOLVED, that the Mental Health Board of San Francisco adopts as its special mission, in concert with other advocates and advocacy organizations, to ensure that the Mental Health Services Act as implemented in San Francisco remains true to its intent, namely to transform the mental health system. (Passed unanimously.)

## RESOLUTION (MHB-2005-10): ENDORSING NAMI WALKS 2005

WHEREAS, the San Francisco Bay Area chapters of the National Alliance for the Mentally Ill will be holding their first ever NAMIWalks on May 21, 2005, and

WHEREAS, the purpose of the walk is to raise \$150,000-200,000 to fund Bay Area NAMI programs which support family members and clients of the mental health system, including programs which work for improved opportunities for housing, rehabilitation and jobs, and that provide public education about mental illnesses, and

WHEREAS, these programs will be made available to everyone without charge, and

WHEREAS, the NAMIWalks event itself will help publicize the damage discrimination against the mentally-ill does, and the need to end all forms of stigma against the mentally ill, and

WHEREAS, the Mental Health Board recognizes the San Francisco Bay Area chapters of NAMI as an essential part of our local community of mental health advocates, now therefore

BE IT RESOLVED, that the Mental Health Board of San Francisco commends and thanks the San Francisco Bay Area chapters of the National Alliance for the Mentally Ill for all their work on behalf of those with mental illness and their families, and

BE IT FURTHER RESOLVED, that the Mental Health Board of San Francisco endorses the NAMIWalks which will be held on May 21, 2005. (Passed unanimously.)

Dr. Turner: At the next Executive Committee meeting, we'll talk about getting our committees active again, namey Budget and Stakeholders.

I met recently with Barbara Garcia and Bob Cabaj about the MHB Hearing at the end of the Proposition 63 planning process. They are asking that the MHB hold hearings at each of the Task Force meetings. We would like MHB members to sign up to be at the meetings. I think that's a good role to play. I think it's really important to hear from the public as we go along.

Mr. Medema: The meetings will be every three weeks in different parts of the city. So we're asking that someone from the MHB be at those meetings every three weeks.

Dr. Turner: I'd like to ask Board members to talk about the Proposition 63 training held in Berkeley.

mr. martin: They were trying to be very inclusive. They started out assuming everybody knew nothing. So it was only in the last 3-4 hours that they got to the information we needed. But the process was very good. It was very inclusive. It was almost too inclusive. But all in all it was a nice get together, and we got to compare notes with

other MHBs around the state. And we're really lucky in San Francisco that we have the mental health system that we do. In one county the Board of Supervisors has gone on record that Proposition 63 was a travesty, and is going to instruct their mental health director not to accept any of the funding.

Ms. Walker: One of the things the Act should support is respite care. It came up again and again.

Dr. Turner: I felt the same as Chance, I was hoping for more specific information, but I appreciated meeting chairs from other Mental Health Boards.

Ms. Wilson: I really liked meeting people from other boards.

## **5.0 ELECTION OF OFFICERS**

LaVaughn Kellum-King was elected to fill an unexpired term as Vice Chair of the Mental Health Board with her term running to the MHB meeting in February 2006.

Michael Medema was elected to fill an unexpired term as Secretary of the Mental Health Board with his term running to the MHB meeting in February 2006.

## **6.0 NEW BUSINESS**

Mr. Medema: An idea was discussed at our Retreat to relocate our meetings to City Hall. I've done research and will present it to the Executive Committee. And I hope to present it at the April Board meeting.

Dr. Turner: Thank you for doing that research.

Mr. Luebke: Tonight's program was one of the best in the last two years. One thing that was nice is that we got real, tangible things we can do as individuals, and it would be neat to see more of that.

Dr. Turner: We asked Dr. Okin in advance for that.

## **7.0 PUBLIC**

Mr. Pilpel: I suggest putting the bridge barrier on your agenda for the next meeting to take a position about it.

Dr. Bingham: I've recently opened a new clinic in San Francisco that I think could be a good model for Prop 63. (Golden State Psychological Health Center, [www.gsphc.net](http://www.gsphc.net))

Mr. Kalman: I would like Rec and Parks to be considered. They should have more recreation programs for people with mental disabilities.

## **8.0 ADJOURNMENT**

There being no further business, the meeting was adjourned at 8:37 p.m.



# SAN FRANCISCO MENTAL HEALTH BOARD

Gavin Newsom  
Mayor

1380 Howard Street, Suite 510  
San Francisco, CA 94103  
(415) 255-3474 fax: 255-3760  
mhb@igc.org  
www.sfgov.org/mental\_health

## MEETING OF THE MENTAL HEALTH BOARD

Wednesday, April 13, 2005  
1380 Howard, Room 537  
6:30 p.m.

### AGENDA

Public comments will be taken for each agenda item.

#### 1.0 CALL TO ORDER AND CONSENT CALENDAR (5 minutes) DOCUMENTS DEPT. For discussion and proposed action.

APR 11 2005

##### 1.1 Call to Order and Announcements from the Chair

SAN FRANCISCO  
PUBLIC LIBRARY

##### 1.2 Consent Calendar

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of March 9, 2005, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of April 13, 2005 to the following members:

#### 2.0 PRESENTATION: TEEN ACCESS TO MENTAL HEALTH SERVICES (50 minutes)

Sai-Ling Chan-Sew, Director of SF Children's Mental Health Services  
Dr. Miriam Martinez, Director, UCSF Infant, Child, and Adolescent Psychiatry.

##### 2.1 Discussion of Possible Future Actions Related to Presentation (10 minutes)

#### 3.0 DIRECTORS REPORTS (20 minutes) For discussion.

3.1 Report from the Director of Community Behavioral Health Services  
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board  
A report including updates and announcements regarding the activities and operations of the Board.

#### 4.0 MENTAL HEALTH BOARD COMMITTEES (15 minutes) For discussion and proposed action

##### 4.1 Report of the Chair of the Board and Executive Committee



The Chair will report discussions and actions of Executive Committee.  
Discussion of budget policy and strategy.

4.1.a Report from the Board Members on meetings and conferences attended.

4.1.b PROPOSED ACTION: Resolution in Support of a Suicide Barrier for the Golden Gate Bridge.

4.1.c PROPOSED ACTION: Resolution in Support of the Health Commission's Position on Not Accepting Budget Cuts to Community Behavioral Health Services

## **5.0 NEW BUSINESS (5 minutes)**

Suggestions for future agenda items or issues the Board might consider looking into.

## **6.0 PUBLIC COMMENT (5 minutes)**

This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

## **7.0 ADJOURNMENT**

### **DISABILITY ACCESS**

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD). Five days notice before the meeting will help to ensure the presence of an ASL interpreter or sound enhancement system. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and 14 Mission. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley which runs on the opposite side of the building from 10th Street.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

### **POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES**



The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

### **KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE**

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Donna Hall  
Sunshine Ordinance Task Force  
City Hall, Room 244  
1 Dr. Carlton B. Goodlett Place  
San Francisco, CA 94102-4689  
Telephone: (415)554-7724  
Fax: 4(15) 554-5163  
E-mail: Donna\_Hall@ci.sf.ca.us

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To view Mental Health Board agendas and minutes, you may visit the MHB web page at: [www.sfgov.org/mental\\_health](http://www.sfgov.org/mental_health). You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

### **Lobbyist Registration and Reporting Requirements**

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site [www.sfgov.org/ethics](http://www.sfgov.org/ethics).





## SAN FRANCISCO MENTAL HEALTH BOARD

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### MENTAL HEALTH BOARD ATTACHMENT A April 13, 2005

#### PROPOSED RESOLUTION (MHB-2005-xx): SUICIDE BARRIER FOR THE GOLDEN GATE BRIDGE

WHEREAS, the Golden Gate Bridge is the number one suicide site in the world, and

WHEREAS, there have been over, 1,250 suicides from the Golden Gate Bridge, or 2 suicide deaths per month, since it was constructed, and

WHEREAS, suicide from the Bridge is too easy and too final, and

WHEREAS, John Kevin Hines, a survivor of a jump from the Bridge, and now a suicide prevention educator has said, "The minute I let go of the Bridge, I knew I didn't want to die," and

WHEREAS, one study of 515 suicide attempters who were taken from the bridge before jumping found that after 25 years, 94% were still alive or had died of natural causes, thus showing that suicide is most often a desperate, impulsive, time-limited act that can be prevented, and

WHEREAS, in 1936, Joseph Strauss, the bridge architect, guaranteed that "suicide is neither possible nor probable," with his original 5'6" guardrail, instead of the current 4' guardrail, and

WHEREAS, other major monuments, such as the Eiffel Tower and the Empire State Building, have constructed barriers and virtually eliminated suicide, now therefore

BE IT RESOLVED, that the Mental Health Board of San Francisco declares its support for the building of a suicide barrier on the Golden Gate Bridge, and

BE IT FURTHER RESOLVED, that the Mental Health Board expresses its gratitude and appreciation to the Golden Gate Bridge Board of Directors for voting 17-1 on March 11, 2005, to proceed with the preliminary plans and design for a physical suicide barrier, for accepting the cost estimate of \$2 million, and for directing staff to investigate possible public and private funding sources, and

BE IT FURTHER RESOLVED, that the Mental Health Board expresses its gratitude and appreciation to all the San Francisco representatives on the Bridge Board of Directors for their support of the barrier, specifically: Supervisor Tom Ammiano, Supervisor Bevan

Dufty, Maryanne Harrison, Sabrina Hernández, Supervisor Jake McGoldrick, Janet Reilly, Supervisor Gerardo Sandoval, Leah Shahum, and Stanley Smith, and

BE IT FURTHER RESOLVED, that the Mental Health Board expresses its gratitude and appreciation to the Metropolitan Transportation Commission for setting aside \$1.6 million for the barrier planning and design, and

BE IT FURTHER RESOLVED, that the Mental Health Board urges the Golden Gate Bridge Board of Directors to proceed with implementation as quickly as possible, and that the Mental Health Board urges the City and County of San Francisco to contribute to the \$400,000 local match for planning and design.

From: Paul Muller <pmuller@mullerandsmith.com>  
 To: <mhb@igc.org>  
 Date: Tuesday, March 29, 2005 1:09 PM  
 Subject: Bridge Barrier Update #4

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meetings

This is the fourth Golden Gate Bridge Suicide Barrier Update from the Psychiatric Foundation of Northern California. PFNC has launched an advocacy project dedicated to fostering the construction of a suicide barrier on the bridge, and we plan to keep these email newsletters going during the campaign. We hope you find them informative and useful—let us know what you think.

---

NEWSFLASH:

WE ARE OVER HURDLE #1

Hardly a news flash, as by now most all interested know the Bridge District voted on March 11 to proceed with the preliminary plans and design for a physical suicide barrier. The vote was 15-1 and followed a period of testimony from 12-15 barrier supporters and three opponents. No funding was committed in this action and the staff estimate of \$2 million was accepted, with the understanding that staff would look for public or private sources of funding.

MONEY MOST OVER HURDLE #2

Money rumors have been swirling since bridge staff mentioned, "there might be some funds from MTC" during the hearing on March 11. Most recently SF Supervisor Tom Amiano announced \$1.6 had been set aside by MTC and a Bridge District committee recommended Thursday they formally seek the funds.

While 1.6 million is a major step forward, an additional \$400,000 is needed as the local match. Marin County has pledged \$100,000 towards this effort and we anticipate working with other public and private organizations to complete the funding package.

WHO IS MTC?

The Metropolitan Transportation Commission is the regional agency responsible for distributing Federal Highway funds in the Bay Area. They are likely to play a key role funding barrier construction after the planning process is complete. More information is at [www.mtc.ca.gov](http://www.mtc.ca.gov).

SUPPORT AND OPPOSITION

At the Bridge Board meeting of March 11, staff distributed a tally sheet of comments for and against a physical suicide barrier. In support were 1117 comments. Letters and signatures, opposed were 148. The largest block of comments in support were 861 petition signatures gathered by Patrick Fitzgerald, followed by 176 individual emails and 72 letters received from Kaiser Medical Centers in the Bay Area.

Several supporters expressed concern that we were behind 85% to 15 % in a recent on-line Chronicle poll. Two points are in order here. First, you might want to read the disclaimer published by the Chronicle, which states these polls are not valid statistical samples. Second, the total responses to this poll were very small. The Chronicle regularly gets 1,500 to 2,000 respondents to their on line polls. The Barrier question got less than 400 responses.

COMING UP

AT THE DISTRICT

There are a number of important Bridge District meetings coming up in April. These will include formal action to seek the MTC money and a start of the discussion for revision of the District's suicide barrier criteria. We will have more in the next Update.

BRIDGE ANNIVERSARY

May 27th is the 68th anniversary of the bridge opening. PFNC is planning a series of events involving public speaking, community presentations and a major press announcement. Stay tuned.

Paul Muller  
Consultant to  
Psychiatric Foundation  
of Northern California

PS: Please forward this note to friends and colleagues who may be interested. We could use their support, too!

If you wish to be removed from this list, send us a note by going to [www.pfnc.org](http://www.pfnc.org) and clicking on „contact us.“

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February 24, 2005  
(For Board: March 11, 2005)

**REPORT OF THE BUILDING AND OPERATING COMMITTEE/  
COMMITTEE OF THE WHOLE**

Honorable Board of Directors  
Golden Gate Bridge, Highway  
and Transportation District

Honorable Members:

A meeting of the Building and Operating Committee/Committee of the Whole was held in the Board Room, Administration Building, Toll Plaza, San Francisco, California, on Thursday, February 24, 2005, at 10:00 a.m., Chair Eddie presiding.

**Committee Members Present (8):** Chair Eddie; Vice Chair Reilly; Directors Ammiano, Boro Martini, Smith and Stroeh; President Middlebrook (Ex Officio)

**Committee Members Absent (1):** Directors Hernández

**Other Directors Present (8):** Directors Brown, Cochran, Dufty, Harrison, McGoldrick, Murray, Pahre and Shahum

**Committee of the Whole Members Present (16):** Directors Ammiano, Brown, Cochran, Dufty, Eddie, Martini, McGoldrick, Murray, Pahre, Reilly, Shahum, Smith and Stroeh; Second Vice President Boro; First Vice President Harrison; President Middlebrook

**Committee of the Whole Members Absent (3):** Directors Hernández, Kerns and Sandoval

**Staff Present:** General Manager Celia G. Kupersmith; District Engineer Denis J. Mulligan; Auditor-Controller Joseph M. Wire; Secretary of the District Janet S. Tarantino; Attorney David J. Miller; Deputy General Manager/Bridge Division Kary H. Witt; Deputy General Manager/Bus Division Susan C. Chiaroni; Deputy General Manager/Ferry Division James P. Swindler; Deputy General Manager/Administration & Development Teri W. Mantony; Public Information Director Mary C. Currie; Assistant to the General Manager Amorette Ko; Assistant Clerk of the Board Karen B. Engbretson; Assistant Clerk of the Board Trainee Patsy Whala

**Visitors Present:** John Kevin Hines, suicide survivor; Patrick Hines, father of John Kevin Hines; Mel Blaustein, M.D., Psychiatric Foundation of Northern California; Martha Stookey and Joan Quan, International High School; Mary Zablotsky, Sarah Cherny, Robert Cherny, Renee Milligan and Dave Hull, relatives of suicide victims; Roger Grimes, Joyce Pavlovsky and Karen Fitzgerald, suicide prevention advocates; Eve Meyer and John Vidaurre, San Francisco Suicide Prevention, Inc., Robert Guernsey, Citizens for a Safe Golden Gate Bridge; Anne Fleming, M.D., psychiatrist at San Francisco General Hospital; Mike and Terry Oxford, San Jose residents; Bruce Gurganus, County of Marin Mental Health Director



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1. Discussion Relative to Process for Development of a Physical Suicide Deterrent System on the Golden Gate Bridge

In a memorandum to Committee, District Engineer Denis Mulligan and General Manager Celia Kupersmith provided an informational report outlining the procedures necessary to undertake development of a physical suicide deterrent system on the Golden Gate Bridge. The report stated that development of such a system would require extensive engineering analysis and environmental review, a process estimated to take up to two years and cost as much as \$2 million to complete. This \$2 million cost would not include the cost of developing final plans and specifications. The development process would also be subject to state and federal involvement due to the desire to have the project eligible for federal funding. Final design and construction would occur following the initial two-year engineering and environmental review process.

The report provided an overview of the process required to be undertaken prior to construction of any physical suicide deterrent system, including development of an array of reasonable alternatives and completion of the environmental review required by the California Environmental Quality Act (CEQA) and the National Environmental Policy Act (NEPA). The process would include the following steps to be completed:

- Following Board approval to proceed with the project, the Board would need to adopt a list of criteria for the evaluation of alternatives for a physical suicide deterrent system;
- Concurrently develop a "Purpose and Need" statement and obtain Federal Highway Administration (FHWA) concurrence with the statement, pursuant to CEQA/NEPA;
- Review prior proposals for a physical suicide deterrent system on the Golden Gate Bridge, as well as designs that have been implemented on other bridges;
- Issue a Request for Proposals (RFP) to engage consultants to undertake the preliminary engineering and environmental work on the project;
- Solicit feedback from the Psychiatric Foundation of Northern California and suicide prevention organizations in San Francisco, Marin and Sonoma counties specifically regarding the adequacy of the alternatives as a potential physical suicide deterrent;
- Undertake wind tunnel tests and analysis of the alternatives to ensure the feasibility of the design, both with and without the installation of a moveable median barrier on the Bridge structure;
- Perform a Visual Analysis of the workable alternatives, including preparation of several still photographic simulations from various perspectives;
- Prepare an historic "106 Evaluation" in consultation with the State Historic Preservation Office (SHPO); and, if necessary, the Federal Advisory Council on Historic Preservation (ACHP); and, prepare a "Section 4(f)" Report;
- Solicit feedback from the San Francisco Bay Conservation and Development Commission's (BCDC) Design Review Board and Engineering Criteria Review Board regarding the alternatives;
- Incorporate the above-noted analysis, evaluations and reports into a *Draft Environmental Assessment/Initial Study* for FHWA approval and subsequent public release;

**REPORT OF THE BUILDING AND OPERATING COMMITTEE/  
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- Hold a public hearing to provide for full public disclosure and comment;
- Following public review of the workable alternatives, prepare responses to public comments, incorporating changes as appropriate;
- Simultaneously, the District would execute Memorandum of Agreement with SHPO, FHWA, and GGNRA, and obtain FHWA Section 4(f) approval; and,
- Nearing the end of the process, staff will finalize the environmental document pursuant to CEQA and NEPA.

The report noted that the ultimate cost to construct the proposed physical suicide deterrent system on the Golden Gate Bridge would be a function of the alternative selected for implementation. Once that alternative is selected and the funding secured for the cost of the final design, staff would prepare final plans, specifications and estimates (PS&E) and obtain necessary regulatory permits. The report noted that if the Board chose to move forward with final design before the environmental document is adopted, any design work undertaken before the environmental document adoption would not be eligible for federal funding and could not qualify as matching funds for any federal funding of the construction phase of the project. A copy of the report is available in the Office of the District Secretary.

At the meeting, Denis Mulligan summarized the staff report, noting that the projected two-year timeframe for the engineering analysis and environmental review would be an ambitious schedule, considering the amount of regulatory steps prescribed by state and federal law. He described those regulatory steps in detail, noting that since the Golden Gate Bridge is an historic structure, the historic preservation review process would likely be the longest duration activity within the proposed workplan. He further noted that the review process would also include input from key project stakeholders, such as the Psychiatric Foundation of Northern California and various suicide prevention organizations.

Mr. Mulligan also stated that the Board of Directors would be provided project updates and opportunities for decisions at key milestones, including an initial adoption of evaluation criteria, review of the array of alternatives and selection of the preferred alternative. In addition, the Board could choose to expand the level of public involvement in the review process above and beyond that set by state and federal law, understanding that increasing public involvement might add additional time to the schedule. He further described the technical details associated with wind tunnel studies, since any structural change to the aerodynamic form of a long span suspension bridge would affect its stability under high winds. In conclusion, Mr. Mulligan noted that since a physical suicide deterrent project is currently not included in the District's capital budget, the District would need to obtain \$2 million of new monies from some new source, or the District could defer a currently budgeted capital maintenance project or the District could implement a \$2 million reduction in services in its operating budget.

Celia Kupersmith stated that in 1998, the Board authorized conceptual approval for the installation of a one-foot wide moveable median barrier on the Golden Gate Bridge. Therefore, if wind tunnel testing were undertaken, it would be prudent to include

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evaluations of the physical suicide deterrent system both with and without the moveable median barrier.

Prior to the public comment, a brief discussion by Board members ensued, including the following:

- Director Martini made the following comments and inquiries:
  - He inquired as to which capital projects could possibly be deferred in order to fund the \$2 million in studies for a physical suicide deterrent system. In response, Mr. Mulligan stated that other than capital purchases of Bridge maintenance equipment, the largest upcoming Bridge maintenance capital project is the Main Cable Recoating project, which has already been deferred since 2000 for a variety of reasons, and which the District should not defer further. Mr. Mulligan further stated that the District could apply for state and federal grants for the suicide deterrent project, but would have to compete with other agencies for the limited funding available.
- Director Ammiano made the following comments:
  - He commended District staff for their hard work in preparing such a comprehensive report in such a short time.
  - He cautioned the Board to be careful not to make “either/or” decisions, wherein an important capital project would have to be delayed or eliminated in order to undertake a physical suicide deterrent project.
  - He noted that funding may be available for the project from the San Francisco Department of Public Health.
  - He emphasized the importance of engaging the mental health community, who may be willing to provide pro bono services for the project.
  - He inquired as to whether architectural aesthetics could be blended into the project. In response, Mr. Mulligan cited the example of the Golden Gate Bridge Public Safety Railing project, which benefited from the involvement of an Architectural Advisory Panel.
- Director McGoldrick inquired as to the comparative estimated costs of preliminary studies, design and construction for both a moveable median barrier and a physical suicide deterrent system. In response, Mr. Mulligan stated that those costs are estimated as follows: (1) moveable median barrier – preliminary studies, \$2 million and design/construction, \$20 million (in 2004 dollars); and, (2) suicide deterrent – preliminary studies, \$2 million and design/construction, \$15-25 million (depending on alternative selected).
- Director Murray made the following comments and inquiries:
  - She stated that she wholeheartedly supports a suicide deterrent system on the Golden Gate Bridge, and believes that such a system could be

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constructed while still maintaining both the structural and aesthetic integrity of the Bridge.

- She urged the Board to revisit the criteria for a suicide deterrent as soon as possible.
  - She stated that the Board should not belabor funding issues, noting that in her opinion, once the District embarks on a physical suicide deterrent project, funding would become available from a variety of sources. She stated that the County of Marin would take action to support development of a suicide deterrent system and commit County funds for the project. In addition, she stated that the Marin Community Foundation could help with local grants or fundraising efforts.
- Director Reilly made the following comments and inquiries:
    - She noted that \$2 million represents only 1% of the District's total budget, and that is important that the District commit to developing a physical suicide deterrent system in order to save lives.

**Public Comment**

The following members of the public expressed their support for a physical suicide deterrent system on the Golden Gate Bridge:

1. John Kevin Hines, who survived a jump off the Golden Gate Bridge in 2000;
2. Patrick Hines, father of John Kevin Hines;
3. Dr. Mel Blaustein of St. Francis Memorial Hospital;
4. Karen Fitzgerald, advocate for a physical suicide deterrent system on the Bridge;
5. Martha Stookey, Teacher at International High School, supporting the family of suicide victim Jonathan Zablonty;
6. John Vidaurri, San Francisco Suicide Prevention, Inc.;
7. Mary Zablonty, mother of suicide victim Jonathan Zablonty;
8. Roger Grimes, advocate for a physical suicide deterrent system on the Bridge;
9. Joyce Pavlovsky, advocate for a physical suicide deterrent system on the Bridge;
10. Sarah Cherny, partner of suicide victim Philip Holsten;
11. Joan Quan, parent at International High School, supporting the family of suicide victim Jonathan Zablonty;
12. Robert Cherny, father of Sarah Cherny and friend of suicide victim Philip Holsten;
13. Eve Meyer, Executive Director of San Francisco Suicide Prevention, Inc.;
14. Robert M. Guernsey, Citizens for a Safe Golden Gate Bridge;
15. Anne Fleming, friend of suicide victim Philip Holsten;
16. Terry and Mike Oxford, parents of suicide victim Jennifer Marie Oxford;
17. Bruce Gurganus, Mental Health Director for County of Marin;
18. Renée Milligan, mother of suicide victim Marissa Imrie; and,
19. Dave Hull, father of suicide victim Kathy Elizabeth Hull.

Following the public comment period, discussion by Board members resumed, as follows:

- Director Harrison made the following comments:

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- She expressed her support for a physical suicide deterrent system, but noted that following three years of service cut backs, layoffs and deferment of capital projects important to the sustainability of the Bridge structure, the District does not have \$2 million in available funding to begin the project.
- She suggested that perhaps revenue from the implementation of a bicycle and pedestrian toll could be earmarked to pay for a suicide deterrent system.
- Director Shahum made the following comments:
  - In response to Director Harrison's comment stated above, Director Shahum respectfully disagreed, stating that it would be inadvisable to connect the two projects.
- Director Boro made the following inquiries and comments:
  - He inquired as to the feasibility of installing a safety net underneath the Bridge as a suicide deterrent. In response, Mr. Mulligan explained that such a net could be problematic, particularly for rescue efforts by District and law enforcement personnel.
  - He stated that the District has an obligation to pursue studies of a moveable median barrier as well as to pursue studies of a physical suicide deterrent system, and concurred with the General Manager's suggestion that wind tunnel testing be performed simultaneously on both types of proposed structures.
  - He noted that the District always retains the option of completely closing down access to the Bridge sidewalks, although, in his opinion, he stated that this would not be a reasonable option.
- Director Ammiano made the following inquiries and comments:
  - He suggested that creative funding solutions be pursued, such as public-private partnerships or state mental health funding, and that it would be prudent for the District to collaborate with experts in the mental health community in developing the project.
  - He stated his confidence that a practical solution will be found, and urged the Board to expedite the process of developing a physical suicide deterrent system.
  - He suggested that the District solicit the support of California Senators Feinstein and Boxer and to consider requesting that the CEQA/NEPA environmental review process be waived due to the seriousness of the suicide issue.
  - He suggested that a special task force or advisory committee be formed to discuss funding for both the suicide deterrent project and the moveable median barrier project.
- Director Smith suggested that he would pursue the possibility of having volunteer union construction forces assist with any eventual construction of a physical suicide deterrent system.

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- Director Martini made the following comments:
  - He noted that the question of a physical suicide deterrent system is not solely a District issue, but should involve the community at large in seeking funding and design solutions.
  - He noted the difference between a moveable median barrier and a physical suicide deterrent system with respect to the District's level of liability.
  - He cautioned that before embarking on development of a physical suicide deterrent system, the Board should consider other factors, such as the feasibility and cost of a moveable median barrier, the District's ongoing budgetary constraints and the District's obligations to its employees as well as its Bridge and transit customers.
- Director Reilly made the following comments and inquiries:
  - She suggested that the public be engaged in the process, perhaps by holding a physical suicide deterrent system design contest to solicit creative solutions from the design community.
  - She urged the Board to find the \$2 million in funding and proceed with the project as soon as possible.
- Director Murray made the following comments and inquiries:
  - She stated that she believes that developing a physical suicide deterrent system is not only a public health issue, but also a public safety issue.
  - She urged the Board to take action on proceeding with development of a physical suicide deterrent system at this time.
- Director Brown inquired as to whether a horizontal suicide deterrent, extending laterally out from the Bridge sidewalks, could be feasible. In response, Mr. Mulligan answered in the affirmative, noting that such a design could be studied as one of the alternatives.
- Director Duffy made the following comments:
  - He urged the Board to move forward with development of a physical suicide deterrent system as expeditiously as possible.
  - He pledged his time and effort to the project and stated that with his 14 years of political experience in Washington, D.C., he would assist in seeking federal funding for the project.
- Chair Eddie expressed his appreciation to the public speakers on behalf of the Committee of the Whole for the courtesy and respect they showed towards the members of the Board of Directors, as well as the eloquence of their presentations.
- Director Pahre cautioned the Board not to let the sense of urgency regarding a physical suicide deterrent system overtake the District's obligations to undertake concurrent projects already in process. She noted that realistically, the



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preliminary studies for a physical suicide deterrent system would take 18 months to two years to undertake.

- President Middlebrook made the following comments:
  - She expressed her thanks to the public speakers, noting that the Board members have been deeply touched by the emotional testimony.
  - She stated that the Board of Directors has made extraordinary efforts over the past few years to solve its fiscal crisis, including the painful process of layoffs. She further stated that while the District's financial deficit is still quite serious, the will of the Board appears to be supportive of moving forward with development of a physical suicide deterrent system.
  - She urged fiscal caution while proceeding with the project.

Celia Kupersmith suggested that, based upon the Committee's discussion, it would be appropriate for the Committee to take action at this time to support proceeding with the study of a physical suicide deterrent system on the Golden Gate Bridge, as outlined in the staff report, beginning with the reassessment of the criteria for an effective suicide deterrent, and to direct staff to develop creative funding solutions for such a project, including seeking funding from public and private sources.

Staff recommended and the Committee concurred by motion made and seconded by Directors MARTINI/SMITH to forward the following recommendation to the Board of Directors for its consideration:

**RECOMMENDATION**

The Building and Operating Committee recommends that the Board of Directors approve proceeding with development of a physical suicide deterrent system on the Golden Gate Bridge; with the understanding that the first steps will include identifying and pursuing funding from local, state, federal and other sources for the initial design and environmental studies required prior to undertaking construction of a physical suicide deterrent system, and the development of evaluation criteria for use in said studies, as outlined in the attached resolution.

**Action by the Board - Resolution**

AYES (12): Directors Ammiano, Brown, Cochran, Dufty, Eddie, Martini, Pahre, Shahum and Smith; Second Vice President Boro; First Vice President Harrison; President Middlebrook

NOES (0): None

2. Authorize Execution of a Professional Services Agreement with Elliott Bay Design Group Relative to RFP No. 2005-FT-6, Consultant to Provide Technical Specifications, Drawings and Contract Support for Spaulding Vessel Refurbishment



**SAN FRANCISCO MENTAL HEALTH BOARD**

---



Gavin Newsom  
Mayor

1380 Howard Street, Suite 510  
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**MENTAL HEALTH BOARD  
ATTACHMENT B  
April 13, 2005**

**PROPOSED RESOLUTION (MHB-2005-xx): SUPPORTING THE HEALTH  
COMMISSION REGARDING BUDGET CUTS**

WHEREAS, major cuts have been proposed to the budget of Community Behavioral Health Services, and

WHEREAS, these cuts would have meant the loss of key programs and staff, and

WHEREAS, these programs would be very difficult to restart, and

WHEREAS, there is an unquestionable need for these programs, and

WHEREAS, the Mental Health Board has taken a consistent position over the past years recommending strongly that the City and County of San Francisco respond to the continual budget crises with revenue strategies rather than cut strategies, and

WHEREAS, the Mental Health Board believes that the budget for Community Behavioral Health Services should be enhanced rather than cut, and

WHEREAS, the Health Commission voted on April 7, 2005, not to accept the proposed cuts to Community Behavioral Health Services, now therefore

BE IT RESOLVED, that the Mental Health Board of San Francisco declares its support for the Health Commission's position on the budget and expresses its gratitude and appreciation to the Health Commission, and

BE IT FURTHER RESOLVED, the Mental Health Board urges Dr. Katz, as Director of Public Health, to do everything in his power to not make cuts to direct services.





# SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510

San Francisco, CA 94103

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## UNADOPTED MINUTES

### Mental Health Board

Wednesday, April 13, 2005

1380 Howard Street, Room 537

San Francisco, CA 94103

6:30 p.m.

DOCUMENTS DEPT.

MAY - 9 2005

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**BOARD MEMBERS PRESENT:** Rebecca Turner, Ph.D. (Chair); Benito Casados, Bob Douglas, J.D.; Supervisor Bevan Dufty; Joel Luebke; Michael Medema; Toye Moses, Ph.D., M.P.H.; Dorothy Shaffer, R.N., N.P., M.S.N.; Lisa Williams; Idell Wilson.

**BOARD MEMBERS ON LEAVE:** LaVaughn Kellum-King; chance martin.

**BOARD MEMBERS ABSENT:** Kate Walker.

### PRESENTERS:

Sai-Ling Chan-Sew, Director, Children, Youth and Family Section, Community Behavioral Health Services

Dr. Miriam Martinez, Director of the Division of Infant, Child and Adolescent Psychiatry for the UCSF Department of Psychiatry at San Francisco General Hospital Campus.

Patrick Gardner, National Youth Law Center, Oakland

**OTHERS PRESENT:** David Pilpel; Emeric Kalman; Mickey Shipley (Conard House, San Francisco Network of Mental Health Clients, CBHS Client Council); Alexander Bingham (Golden State Psychological Health Center); Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

### 1.0 CALL TO ORDER AND CONSENT CALENDAR

The meeting was called to order at 6:42 p.m. by Rebecca Turner, Chair.

Dr. Turner: The Board would like to give a special thank you to Supervisor Bevan Dufty for adjourning the Board of Supervisor's meeting a couple of weeks ago in honor of Officer Mike Cowhig's father. Mike is the former Psych Liaison officer with the San Francisco Police Department and the officer who worked tirelessly with mental health to establish the Police Crisis Intervention Training. Mike's father passed away recently. We truly appreciate Bevan for noticing the obituary and bestowing this honor on Mike's family.

1.2.a RESOLUTION (MHB-2005-11): Be it resolved that the minutes of the Mental Health Board meeting of March 9, 2005, be approved as submitted.

1.2.b RESOLUTION (MHB-2005-12): Be it resolved that the Mental Health Board grant leaves of absence for the meeting of April 13, 2005, to the following members: LaVaughn Kellum-King; chance martin  
(Passed unanimously.)

## 2.0 PRESENTATION: TEEN ACCESS TO MENTAL HEALTH SERVICES

Dr. Turner: We received a letter from students at Urban High School raising the question of access to treatment for teens. As a result of that letter, we've arranged for tonight's presentation.

Dr. Martinez is a UCSF Associate Clinical Professor of Psychiatry and Pediatrics and the Director of the Division of Infant, Child and Adolescent Psychiatry for the UCSF Department of Psychiatry at San Francisco General Hospital Campus.

Mr. Gardner is an attorney with the National Youth Law Center in Oakland. He specializes in laws regarding youth and mental health services.

Ms. Chan-Sew is the Director of the Children, Youth, and Family Section of Community Behavioral Health Services and has worked for CBHS for the past 28 years. In 1996, when she became the Director, she initiated the development of the Children's System of Care (CSOC) in San Francisco in response to a statewide initiative.

Dr. Martinez: Thank you for inviting me. I am a psychologist. I have been working in San Francisco for 15-20 years now. This issue has come up over and over again over the years and various groups have tried to think of ways to decrease barriers to mental health services for youth. The law is very clear on this. The California Family Code (Section 6924) talks about a minor's rights to consent for mental health services. I think it might be better to understand the law first and then the context in which it comes up for minors. Then I can give some case scenarios.

The minor consent law is to help minors trying to access services because of sexual abuse or domestic violence that they don't want to tell their parents about because they are afraid they would get into trouble with their parents. And we as licensed clinicians have to obey the law.

Mr. Gardner: The thing to keep in mind is that the mental health services the minors are entitled to are an entitlement. If you're eligible under state guidelines, then services are mandated.

Minor consent as a basic notion and a matter of state law says children under the age of 18 are entitled to consent to certain services. One subset of those minor consent rules has to do with mental health.

In California, there are two statutes which authorize minor consent. First there is Family Code Section 6924, and then there is the medical necessity criteria for Medi-Cal. If a child meets those statutory regulations then they are entitled to treatment.

The consent provision requires three elements.

1. The child is 12 or older.
2. The minor is mature enough to participate in outpatient services according to the treatment professional.
3. The minor would present serious harm to self or others without treatment or is a victim of incest or child abuse.

Medical necessity requires the following:

1. The minor has to have a listed diagnosis.
2. The minor has to have an impairment as a result of the mental disorder that significantly impairs an important area of life function or a probability of that, or probability that the child will not progress as individually appropriate.
3. The focus of the service is intended to deal with the impairments or make the child better.

There is a financial criterion as well, but I've never seen a child with the kind of income that would disqualify them.

Those are the rules for minor consent mental health services. If they meet those criteria it's a state mandate that you must provide those services and at no cost to the child.

Dr. Martinez: As a provider you do come across teenagers who really do not want their parent to know they are receiving treatment for a variety of reasons. They may not want parents to know if those parents are telling them that they are crazy, that they need to get out of the house, and telling them awful things. Some clinicians are able to meet with that young person one time to determine if these things are true.

In order to call the Access line, you need a parent to call. I called the line just before the meeting tonight and I was told that you do have to have a parent call to make the appointment. Sometimes if you are in a pediatric facility that has access to mental health services you can have a mental health person come right into the pediatric appointment and talk with the child. Under certain circumstances you are allowed to make a follow up appointment.

Every clinician is under an obligation to involve a parent or guardian unless the clinician decides that this appointment is inappropriate and they have to document the situation.

A teen comes in and says, I want to run away from home. Perhaps they have watched their mother getting beaten up all the time. The client might say, "If you tell my mother about this, I'm going to run away." That would put her at risk, so you have to document that, and that you are talking with the minor about bringing a parent into treatment.

In this case we were able to see the client for a few sessions and then bring the parents in and talk with them about the domestic violence. The teen was worried that if she ran away no one would take care of her siblings.

Sometimes we see a young person because they were sexually assaulted. You still do have to document that you're making efforts to involve the parent or guardian or document why it's unwise to do so. I think at a certain age minors should be able to consent for mental health services.

When I meet with a young person, I explain about confidentiality and consent and tell them here are the things I will tell your parents and here are the things I won't. And I will say this to them in front of you.

I'll say to the parents, "If your daughter tells me she's using drugs, smoking, or having sex, those are not things I'm going to talk to you about." Sometimes the parents are relieved to hear that I am going to talk with the young person about that and that I'll be handling those difficult issues.

In working with a young person, I try to meet with the parents from time to time.

If you have a young person who's cutting, but is not suicidal, rather is cutting for other reasons, as a parent I would want to know. And if she cut herself deep one day, I would be upset if her therapist hadn't told me. So as a therapist you find yourself in really sticky situations. That's why many mental health clinicians shy away from doing therapy with young people, because it's challenging since young people engage in risky behavior.

Mr. Gardiner: It's tricky for a therapist to travel through the minefield of all the regulations. Part of the concern is the difficulty in navigating all these competing interests and requirements. The thing I'm most concerned about is the access problem. With young people, if they don't think they can access services confidentially they won't come in and then the risks go up more. The bottom line is what is it that prevents these young people from coming in for care. They don't know about the services and how they work. And the counties are not meeting their obligation to understand the laws to make sure that these services are available.

Dr. Turner: Can children be seen one time for this assessment? Is it legal and do we do it here in San Francisco?

Mr. Gardiner: Absolutely. The law provides for the assessment. That's implicit in the statute.

Dr. Martinez: Once you tell a young person what the confidentiality guidelines are, then they relax about getting consent. A lot of clinicians don't know that it's okay to see a young person one time.

Ms. Chan-Sew: You heard Patrick and I worked with Patrick several years ago. How we do it here in San Francisco is that we follow the law. And I'm very sorry to hear that Access said an adolescent can not call for services, because I've worked very hard with

Access to get that clear that adolescents CAN call. I'd like to get the name of the person you talked to, Miriam, so I can follow up. And I try to reinforce it with the providers because all our clinics are access points. We try to do what Miriam is describing—explaining the law and offering help.

But that's probably not enough. We serve 4,600 children and youth in a year. About 70% are over 10 years old. Young people don't see clinics as friendly. So instead of trying to approach it that way, I try to expand our work to collaborate with other youth serving agencies. We have many, many contracts and now we have contracts with six new agencies.

For example, we have a contract with Huckleberry, which runs a program to divert youth from being detained in Juvenile Hall. We work with Columbia Park Boys and Girls Club, the Sunnysdale Boys and Girls Club, and Mosisanna West. We have a contract with the Urban Services YMCA which has a program at Gloria Davis Middle School.

And this year we are working on bringing clinical services to substance abuse programs such as Henry Ohloff and Horizons Unlimited. We're making mental health services available to youth on site. We're meeting the spirit of the law, but at the same time finding ways to increase access for youth.

Mr. Gardner: Is there a limit on the number of visits a child can have in San Francisco under minor consent?

Ms. Chan-Sew: The law says you have to provide services. My instruction to staff is that they will provide the initial assessment.

Mr. Gardner: How long can an assessment take? 50 minutes?

Ms. Chan-Sew: It can take up to two hours.

Mr. Medema: If they meet the criteria, then how long can they be in treatment?

Ms. Chan-Sew: Then they can have services as long as they need them.

Mr. Medema: Is that the policy?

Ms. Chan-Sew: Yes.

Dr. Martinez: I want to point out how hard this is for a practitioner. It's hard to provide that service. It's a balancing act.

Mr. Gardner: The way the counties have interpreted the provision depends on how they get funded. If you have a fee for service they relax that provision. When they no longer get paid for it, then that provision gets tightened. Our view is that the counties should err on the side of providing services. I would say that assessments are not limited to one visit under the regulations.



Ms. Chan-Sew: The policy for CBHS is that you do an initial assessment, and that means that if you need more time, you take more time. You can take however long you need in order to complete the assessment.

Mr. Douglas: I may be hopelessly outdated, but parents are hopefully controlling the situation of the kids. This minor consent arrangement should be an exception. It should be an exception when you don't include the parents.

Mr. Garnder: Sometimes the child doesn't agree with including the parents and sometimes the parent is the problem.

Mr. Medema: In California, a child can get an abortion, which is a risky procedure, without parental consent. A child can get HIV testing and take or not take medications without parental consent. But a child can't receive mental health services without parental consent.

I want to say that I agree that in all of those instances the goal is for parental involvement. If I were a parent I would want to know if my child were pregnant and debating an abortion or if my child were HIV positive. But I also am concerned about gay teens who are not comfortable coming out to their parents. We can do surgery on them but not provide mental health services. Is that what the law is?

Mr. Gardner: No, you can get outpatient treatment. You can't get inpatient treatment or medications.

Mr. Medema to Ms. Chan-Sew: Is this how you would like to see the policy of the Department work or would you like to see it changed? I wasn't allowed to get married till the Mayor challenged that law. Is there something stopping from us challenging the state on this?

Ms. Chan-Sew: You hear the advocacy from the Youth Law Center for even more access and wider access. As the director of children's mental health services for the City and County, I have to follow the law. And I encourage everyone in the system to follow the law. From an advocacy viewpoint, though, they are saying the law should be changed.

Mr. Medema: Do you see children in the county who you would like to be providing more services for but you can't because you feel handicapped by the law?

Ms. Chan-Sew: At this point I don't think so, because we are providing our services to youth agencies, and because I think the standard clinics do not provide services well to youth. So we are reaching out to youth in the places where they are and where they go. For example, through our programs in the schools.

Mr. Gardner: It would be a mistake to think that we are seeking changes to the law. What we want to see is that the services are provided, and what we believe is that when the counties take a hit when they provide services, they find all kinds of reasons not to provide services. This is not about the law but about money.

There is an opportunity in the Mental Health Services Act to serve underserved populations. This is an underserved population. For every dollar Ms. Chan-Sew spends on these services it comes out of her pocket.

Dr. Turner: I empathize with your position, Sai-Ling, about not being able to go beyond the law. I'm concerned about the inconsistency. This is a population that will call for services and then they get told no. How can the MHB help make sure there is more consistency in practice in the system?

To get these kinds of things changed, there has to be activism at the state level. This morning I had breakfast with Supervisor Fiona Ma, who if she goes to Sacramento as a member of the State Assembly may be able to help make a difference.

Ms. Chan-Sew: We need to do training and encourage compliance. And we need to look at this from the quality standpoint. What Dr. Martinez said is true, that no matter how much training you do, the clinician in their office makes that decision. We'll continue to do our education and let people know, but I appreciate it if you to tell me when you hear of things like this situation like Dr. Martinez mentioned with the Access line, so I can follow up with the specific clinicians.

Mr. Gardner: Ms. Chan-Sew has done something in this area I haven't seen other counties do. That is to write up a policy directive that's going to come out soon, which is a very valuable tool. She sent it to our staff to comment on it. I urge you to move that document and get it released. I think that is a positive move and we applaud that.

Ms. Chan-Sew: We're talking about taking the policy out to each provider and doing trainings at each site.

Mr. Medema: Where is that document now?

Ms. Chan-Sew: In the City Attorney's office.

Mr. Medema: How long has it been there?

Ms. Chan-Sew: About a month.

Mr. Medema: Can you address what Patrick Garnder said about the money?

Ms. Chan-Sew: Each county was given a block grant from the state and the state looked at the billings for minor consent cases in order to allocate the money to the counties. San Francisco has never billed much for minor consent cases, so we only got a small amount of money. That means that the money is not a significant issue for San Francisco in deciding to provide services or not.

Ms. Shaffer: What is important now is to continuously show the number of kids that need services. There are children who come in who are on drugs and that's a danger to themselves. Or others with mental health impairment. But if the clinician doesn't see that and just sees a behavior problem then they don't get the services they need. I still

think there is an access to care problem. Where do clinicians call to get a definitive answer on these cases? They need a supervisor to provide the consistency.

Dr. Martinez: We do have the policies and procedures from CBHS to follow. It's really clear and you should understand what's in your policy and procedures manual. It's clearly stated. If I went to my director and said, "I don't know what to do," my director would say, "You should open the policy and procedure manual and look at the requirements and fill out the consent form. And you have to sign that form, and it's your license on the line."

You don't need an on-call person. You need to know where the information is. And there's training provided by the County. The emphasis should be more on how to work with young people before they end up meeting this criteria. Instead of waiting for a young person to get to the point they are so depressed they want to hurt themselves. I want to do outreach and prevention. All of us as practitioners have to wait till things get so bad. That's where we need to do some work.

Ms. Shaffer: Opinions about what's desperate differs between clinicians.

Dr. Moses: Dr. Martinez, is there an actual legal requirement?

Dr. Martinez: When I picked up the phone and called the Access line, that's what I was told that adolescents can't call Access on their own.

Dr. Moses: Which one is correct?

Ms. Chan-Sew: I think we need more education for the Access team in terms of when a young person calls. If they say, "I don't want my parent to know, they should offer an assessment appointment at that time. I think in this case with Dr. Martinez, the staff didn't follow the policy.

Mr. Shipley: For the lawyer, most of these statutes talk about a minor 12 or older. I'm concerned about the younger ones who are lost in between that point, because if they are younger than 9 they are eligible for Early Prevention Screening Diagnosis and Treatment) EPSDT. That's how they can get into the system. I know a little bit about incest cases. Sometimes they start at the age of 9, 10, or 11. We need to cover those ages also. These statutes don't seem to cover that.

Mr. Gardner: They do cover it and they say no. A child who is 9 years old cannot consent to mental health services in the State of California.

Claudia: I would like to address minor laws and alcohol and drug abuse treatment. In the fine print, it disallows replacement narcotic treatment. Why is that?

Ms. Chan-Sew: That means they can get treatment for drug abuse, but not including methadone. Methodone is specifically forbidden.

Dr. Martinez: Some of these kids who are doing some of these behaviors are already emancipated.

Mr. Gardner: The rules are different for emancipation. An emancipated child is an adult under law even if not 18 yet. The State has said children can not consent to methadone treatment. That's all that clause says.

Claudia: Then how do you treat minors with narcotic addictions?

Ms. Chan-Sew: If the minor wants the treatment, often the parents want them to get treatment, too. In the case of alcohol and drug abuse treatment, there is great support from families for that.

Juan: By the age of 6, I was physically and sexually molested. I couldn't help but noticing that you use the words "she" and "date rape" and "daughter," and what I discovered when I was growing up is that there are no services for males. I hope we won't continue the same practice. I hope the committees asking for Prop 63 money won't set services based on race, gender, or national origin. I hope they make sure there are services for males.

In Alameda County, they are going to high school campuses with services. I feel we're trying to create another wheel when the wheel is already there.

Dr. Bingham: I'm also a licensed psychologist. I deal with this code. I have to make ethical decisions what's best to serve the kids and what's best to protect my license. It's only when kids fail and you can prove that they've failed, that they can get services. I hope Prop 63 can change that.

Can a clinician's decision be challenged? If the clinician provides services, can someone challenge that and say the clinician was wrong and take the license away?

Ms. Chan-Sew: Working for the County, you know that every step of the way the clinical decision can be challenged. A parent might come back and challenge the decision. They can get another expert to say whatever you decided is wrong. That potentially could happen. But working under the County's umbrella, the County actually protects the provider. If you make that decision under supervision, the County will back you up in the case of a law suit.

Mr. Gardner: Have you ever had a case like that?

Ms. Chan-Sew: No. Where the problem happens is when there are custody battles where one parent gives consent and the other parent doesn't give consent.

Mr. Gardner: And I've never heard of a case.

Mr. Pilpel: 1) On the law, what is the danger of serious mental harm? 2) If there is something you need in terms of state law, Leland Yee is still in the State Assembly. Can he help with this? 3) In the future it might be good to invite the Youth Commission and DCYF. 4) I think you should appreciate the letter from the Urban High advocates.

Dr. Turner: Yes, that letter sparked this presentation and I did send a letter back to them and invited them to come. But I didn't hear from them.

Dr. Martinez: By "mental harm," I would understand that to be that if I don't provide the services, the young person might become so depressed that they might hurt themselves. Or a young person may be headed for a psychotic break. I have to pay attention to that.

Mr. Gardner: This isn't something the lawyers are going to get into. When you give to the clinician the authority to make the determination based on their expertise, then it's up to the clinician.

Ms. Chan-Sew: Another example could be an obsession. That could lead to potential danger to other people that could be very serious. Each scenario is different, but most clinicians have some way of deciding this.

Dr. Turner: Thank you so much to the three of you. This was very informative. I appreciate you taking the time to meet with us.

### **3.0 DIRECTORS REPORTS**

#### **3.1. Report from the Director of Community Behavioral Health Services**

Sai-Ling Chan-Sew reported for Bob Cabaj, Director of Community Behavioral Health.

The highlight is the budget. At the last two Health Commission meetings, there's been significant public testimony about the impact of the cuts. As a result of the hearings, the Health Commission rearranged their priorities in terms of the cuts.

The Health Commission feels that there are no alternative places for mental health and substance abuse services, and that there are some more alternatives for medical care.

Mr. Medema: Can you pass on to Dr. Cabaj and Edwin that during a time of serious budget issues when we are talking about mental health needs, I find it disturbing that one of them is not at our meeting tonight. I'm not saying that I'm not very happy to have you here, but I'd like to have someone representing the entire department rather than just a portion of the department.

Can you tell me the thinking of Dr. Katz about taking people out of residential facilities and putting it into supportive housing? I understand it lowers the cost, but many of those people really need residential care. In supportive housing, often you have only a desk clerk after 5 o'clock.

Ms. Chan-Sew: Dr. Katz said he has found there's not a lot of difference in outcome between people in residential cares as opposed to supportive housing. I think that's what he's saying, though the Health Commission raised questions about that.

Mr. Medema: As the MHB's budget representative, it appears at this point while we are calling them baseline and contingency cuts, that the contingency cuts are going to go into effect because of what we are seeing in the economy.

Ms. Chan-Sew: I will convey your concerns to Dr. Cabaj. He did say he really appreciated all the advocates who came out to testify at the Health Commission Hearings, and that advocacy will be needed at future hearings.

Mr. Medema: Month after month, I register this concern and I want to register it again. The State Welfare and Institutions Code and a City ordinance mandate the MHB to advise the mental health director on the needs of the mental health system. I find that incredibly difficult to do when this Board is not consulted about the budget in advance. Again, please present my concern to Dr. Katz that he does not include this Board in the discussion of budget before it is taken to the Health Commission.

Mr. Douglas: We got an e-mail about cutting the single standard of care.

Ms. Chan-Sew: Supervisor Daly is calling a hearing about this. There were the mid-year cuts in January. We actually had to cut mental health outpatient services. And for clients without medi-Cal coverage, we had to prioritize who would get services and who would not. We are therefore moving away from the single standard of care.

Dr. Moses: I want to agree with Michael. I've been on the MHB for 7 years and this issue comes up again and again. You are right, Michael. I'm glad you're raising this issue. I don't know what else we can do. In defense of Dr. Cabaj, he said he must be in Sacramento on these second Wednesdays.

Mr. Douglas: Do we need to send a letter to Dr. Katz talking about what Michael was saying?

Dr. Turner: We can bring that up in new business.

Mr. Medema: The methadone van program is a phenomenal program. We should do everything we can to support that. And I'm glad that San Francisco is on the leading edge of this program. It really makes a difference for addicts.

Would you let Dr. Cabaj know that I would like him in his report next month to address the concern with the Access Team?

Ms. Chan-Sew: The Access Team is not under the supervision of Dr. Cabaj.

Dr. Turner: That is also a concern that the Mental Health Board has.

Dr. Moses: Also I would like to make a request for Dr. Cabaj to keep in mind diversity when it comes to hiring. I know he just hired two more people. We want him to continue the diversity of staffing. I would like him to discuss the issue of diversity at our next meeting.

Mr. Douglas: Could you tell us about the private providers network?



Ms. Chan-Sew: CBHS contracts with a network of psychiatrists, psychologists, marriage family therapists, and LCSWs. We refer clients to them for treatment. This augments our clinical services.

Mr. Douglas: How do we decide who goes to a clinic and who goes to the PPN?

Ms. Chan-Sew: The clinics take care of cases that are more complex and need a lot of care. The clients that go to the PPN don't need a lot of the additional services.

Mr. Shipley: I had a conversation with an ED of one of the programs that would have been affected by the cuts of the residential programs. He is part of the Human Services Network that represents contractors in residential and drug treatment programs. We are in a lot better position now.

Mr. Medema: The same amount of dollars are being cut, just coming from a different place. That money is not going to be cut from the contracts.

Ms. Chan-Sew: It depends on who you mean by "we." DPH is being cut. It's true that CBHS is being moved to a lower priority for cuts, but this is not really a circumstance for celebration.

Juan: I see there was a training about women released from prison. I'd like to promote the idea of working with males. It seems like we're always segmenting. I don't know why we're always excluding males.

Mr. Pilpel: I want to support Michael's idea for sending a letter to Dr. Katz about consulting with the MHB about the budget cuts before the cuts go to the Health Commission.

The Director's written reported was distributed:

**1. Budget Proposals for FY 05-06.** The Health Commission heard public testimony last April 7 on the proposed 05-06 Department of Public Health (DPH) budget, and decided to push back, from baseline into contingency, proposed budget cuts in behavioral health residential treatment and outpatient services. The Commission de-prioritized the proposed conversion of substance abuse and mental health residential treatment services into supportive housing, which was to save almost \$2.2 million in general funds. \$1.9 million in proposed baseline cuts to outpatient substance abuse services were also moved into contingency. In exchange, other proposed cuts that were in the contingency list were transferred to baseline, including a proposed closure of a primary care center, a 20% reduction in county primary care services, and termination of the contract for UC Crisis Resolution Team. \$3 million in proposed cuts in substance abuse treatment for special populations, as well as \$600,000 in proposed outpatient mental health service cuts, are also still included in the contingency list. The budget is now under discussion with the Mayor's Office.

**2. Planning Begins for the Mental Health Services Act.** The planning meetings in San Francisco for the implementation of the Mental Health Services Act (Proposition 63)



have now been scheduled. The first meeting of the Behavioral Health Innovations Task Force is taking place on Thursday, April 14, 4:00 - 6:00 PM, at the Jean Parker Elementary School, Cafeteria Auditorium, at 840 Broadway St. (near Powell St.), San Francisco. Please help spread the word, and inform all interested stakeholders to attend this first Task Force meeting.

The schedule for the total of six Task Force planning meetings, to be held every 3 weeks from April to July 2005 at rotating locations throughout the city, can be found at the following webpage: <http://www.sfdph.org/Prop63/TaskForceMtgSched.shtml>. These planning meetings will identify needs, priorities, and system capacity strategies for the use of funds from the Mental Health Services Act to expand and transform San Francisco's mental health services system. The meetings will look into: unmet need for mental health services and supports; cultural competence issues facing the system; evidence-based and emerging best practices that can be implemented in San Francisco; opportunities for the integration of services; and incorporation of the Recovery perspective, and the empowerment of consumers and family members. There will be a 30-minute public comment period at every Task Force meeting to allow members of the public the opportunity to speak about the mental health issues that are important to them.

Also, equally important, there will be nine planning sub-committees that will each meet regularly every 3 weeks, in between Task Force meetings. Each planning sub-committee will focus on discussing the needs for Community Services and Supports for one of the following categories of populations of individuals with serious mental illness, and children with severe emotional disturbances:

#### Eleven (11) Planning Sub-Committees:

- Children, Youth & Families

- Transition-Age Youth

- Adults

- Older Adults

- Homeless Mentally-Ill / Housing

- Mentally-Ill Offenders / Criminal Justice involvement

- Vocational / Self-Help

- Consumers

- Family Members

- Prevention/Intervention

- Education and Training

All the sub-committee meetings will be held at the Bill Graham Civic Auditorium, 99 Grove St., throughout the day from 9 AM - 7 PM, on six scheduled meeting dates from April to July 2005.

More information about the implementation of the MHSA in San Francisco can be found at the following DPH website: <http://www.sfdph.org/Prop63/default.htm>.

**3. Priority Focus Set for CBHS Integration.** In a series of meetings in March, the CBHS Integration Advisory Committee identified "improvement of access" as the topmost

priority in the initiative to integrate mental health and substance abuse services in San Francisco. In improving access, the Advisory Committee identified a two-pronged focus for the coming system change effort:

Improvement of access to mental health services for clients in the substance abuse programs.

Improvement of access to substance abuse treatment for clients in the mental health programs.

In the next few months, the Advisory Committee will hold strategic discussions to begin to move forward on this priority area of access, including on:

identifying gaps in behavioral health resources in the overall continuum of care;

improving coordination and collaboration between behavioral health services and programs throughout the system, and with other service-delivery systems;

achievement of dual-diagnosis-capability for all CBHS programs; and

aligning the planning for the Mental Health Services Act with behavioral health integration planning.

The membership of the Integration Advisory Committee will also be expanded to invite a greater number of representatives to include all key sectors having a stake, and an important participation to play, in the behavioral health integration effort. Minutes of the meetings of the Advisory Committee will soon be posted online at: <http://www.sfdph.org/CBHS/default.shtml>.

Meanwhile, CBHS Integration Change Agents had an opportunity to spend a whole day in training with Ken and Chris of ZiaLogic, last March 25. The Change Agents - who are banding fast together in collective team spirit - were trained on: using the COMPASS program self-assessment tool; doing an action plan for their program/agency towards dual-diagnosis capability; facilitating trainings for co-workers; and being effective Change Agents - working within their programs, with fellow clinicians and staff, and contributing towards overall system change.

**4. New CBHS Leaders On Board.** I am very pleased to announce that Aaron Chapman, M.D., has joined us at 1380 Howard St. as the new Medical Director for CBHS. Aaron comes to us with years of experience working at South of Market Mental Health Center and Castro-Mission Health Center. He has been with CBHS for 8 years. Aaron hails from Brooklyn, NY and Pittsburgh PA, and attended medical school at Temple University. He came to the Bay Area for his residency in psychiatry at Stanford. Fortunately for us, the Bay Area is irresistible, so Aaron stayed on. Aaron's particular interest is in mental health-primary care integration. He also has expertise in psychiatric care to individuals with HIV.

I am also very pleased to introduce Natasha Hamilton, the new Director for the MOST AB2034 homeless mental health team. Natasha was the Social Work Supervisor of the

Child Protection Center (San Francisco Human Services Agency) at SFGH. She comes with life experiences working with the homeless mentally ill and substance abuse clients and families. We look forward to her leading San Francisco's best-practice-model AB2034 program.

Welcome aboard, Aaron and Natasha.

**5. Consumer Participation in CBHS Training Activities.** The CBHS System-of-Care Training Committee is making great strides in involving consumers in the design and implementation of system-wide clinical trainings. Two consumers are members of the SOC Training Committee, and participate in selecting and planning annual training curriculums. One of the consumers actually came up with the idea of doing the April 2005 conference on "Working Effectively with Incarcerated Women Released from Jail/Prison." Two other consumers - a peer intern and a clerical intern - assist the training coordinator, Junko Craft, by helping with conference registrations and clerical functions. Both are gaining valuable public relations and computer skills through their work experiences with the Training Committee. The Training Committee also routinely hires consumers who are in vocational training with Community Vocational Enterprises (CVE) to assist at training events and prepare training materials. RAMS Hire-Ability, another consumer vocational services program, provides catering for many of the training conferences. This fiscal year, the SOC Training Committee provided the following consumer-related conferences: "Hoarding and Cluttering: Solutions," "Four Stages of Recovery: Substance Abuse," "Wellness Recovery Action Plan Training," "Desk Clerk Training on De-escalation," and "Reducing Stigma." Kudos to the SOC Training Committee for role modeling involvement of consumers!

On another Training note, the Training Committee is about to select the training topics for next year. Please assist in identifying priority training topics by completing the survey being circulated by the Training Committee. Return the completed survey by May 31, 2005 to Junko Craft at CBHS, 1380 Howard Street, 5th Floor, San Francisco, CA 94103 or fax: (415) 252-3057.

**6. Reducing that Paperwork.** Last year, a group of CBHS staff responded to the concern of many frontline workers that too much time was being spent on required paperwork in mental health services. They formed a Paperwork Reduction Committee, composed of a cross section of staff from the clinics, CBHS billing unit, information systems, and CBHS central administration. Ten months of collaborative teamwork by the group resulted in a streamlining of some CBHS forms; development of two report formats designed to save on clerical support and clinical staff time; and promotion of the use of pre-printed labels to reduce duplication of handwritten information. These changes, adopted last Fall, lessen paperwork demand on CBHS staff. The group also recommended the adoption of an electronic patient record system, which would result in major reductions in paperwork burden. For more info about this initiative, contact Linda Wang (415) 255-3421, e-mail: linda.wang@sfdph.org, or MaryAnn Sullivan at (415) 255-3703, e-mail: maryann.sullivan@sfdph.org.

**7. San Francisco Sponsors Methadone Van Bill.** On April 5, the Health Committee of the California Assembly passed AB631 without opposition, setting the stage for the bill's review by the Assembly Appropriations Committee, and later referral to the

Senate and the Governor. The bill, which was authored by Assemblyman Mark Leno (Democrat, San Francisco), and sponsored by the City and County of San Francisco, would recognize mobile methadone treatment in the State as a valid form of Narcotic Treatment, and allow services provided by such programs to be reimbursed by Medi-Cal. San Francisco DPH currently operates the only mobile methadone program in the State - a pilot program in operation since March 2002. The program originally received grant funding from SAMHSA, which helped DPH purchase and custom-outfit two vans the size of recreational vehicles to provide dispensing services to neighborhoods with high need for opiate treatment services. Over 190 patients have been enrolled to receive treatment on the van, and patients have shown high retention rates, and given positive satisfaction ratings for van services. The van brings treatment to the Mission and Bayview neighborhoods, and van staff have worked closely with community treatment and faith organizations to successfully implement these services.

AB631 is endorsed by the California Medical Society, and the California Association of Peace Officers and Narcotics Officers.

**8. In Memoriam.** Antje Archibald, staff member of the South of Market Mental Health Services, died on March 30, 2005. In her work at the SOMMHC since 1995, she was dedicated to the homeless mentally ill, doing outreach and case management, and performed her work with transition-age youth with energy and commitment. In recent years, she was trained in and used dialectical behavioral therapy as an approach to helping her clients. Antje was an advocate, and strived to reduce system barriers to care. She was also a volunteer for mental health emergency response, assisting victims of hotel fires in the South of Market. We will miss her.

### **3.2 Report from the Executive Director of the Mental Health Board**

Ms. Brooke: The 13th Police Crisis Intervention Training starts next week. Bob and Idell are participating.

Mr. Medema: The City Operations Committee of the Board of Supervisors had a hearing on Prop 63. When Helynnna Arrived at the hearing, I told her she was on the agenda. In two minutes, she filled a page of notes and then spoke eloquently. And I thank you for that, Helynnna.

### **4.0 MENTAL HEALTH BOARD COMMITTEES**

Dr. Turner: In terms of Executive Committee, we discussed moving the MHB meetings to City Hall to Room 421. We'd like to meet there for a few months and see how that goes for us and then have a discussion about it. The room is large enough to hold board members at a conference table and the public around the walls.

Mr. Medema: One of the things I think is good about this is that it will give us increased visibility and access to the Supervisors. Meetings would move from Wednesday to Tuesday.

Dr. Turner: I'd like to welcome Lisa Williams to the Board, a new member appointed by Supervisor Fiona Ma

Ms. Williams: I've been appointed to a Family Member Seat. I have been involved in mental health for years, focusing on youth and working with homeless children. I have a family member who took her life due to mental health issues.

Dr. Turner: We look forward to working with you. Dr. Moses: I think Lisa is a great addition to our board. She is well-known in this community.

Dr. Turner: I want to announce that Michael Medema will be the chair of the Mental Health Board's Budget Committee.

#### **RESOLUTION (MHB-2005-13): SUICIDE BARRIER FOR THE GOLDEN GATE BRIDGE**

**WHEREAS**, the Golden Gate Bridge is the number one suicide site in the world, and

**WHEREAS**, there have been over, 1,250 suicides from the Golden Gate Bridge, or 2 suicide deaths per month, since it was constructed, and

**WHEREAS**, suicide from the Bridge is too easy and too final, and

**WHEREAS**, John Kevin Hines, a survivor of a jump from the Bridge, and now a suicide prevention educator has said, "The minute I let go of the Bridge, I knew I didn't want to die," and

**WHEREAS**, one study of 515 suicide attempters who were taken from the bridge before jumping found that after 25 years, 94% were still alive or had died of natural causes, thus showing that suicide is most often a desperate, impulsive, time-limited act that can be prevented, and

**WHEREAS**, in 1936, Joseph Strauss, the bridge architect, guaranteed that "suicide is neither possible nor probable," with his original 5'6" guardrail, instead of the current 4' guardrail, and

**WHEREAS**, other major monuments, such as the Eiffel Tower and the Empire State Building, have constructed barriers and virtually eliminated suicide, now therefore

**BE IT RESOLVED**, that the Mental Health Board of San Francisco declares its support for the building of a suicide barrier on the Golden Gate Bridge, and

**BE IT FURTHER RESOLVED**, that the Mental Health Board expresses its gratitude and appreciation to the Golden Gate Bridge Board of Directors for voting 17-1 on March 11, 2005, to proceed with the preliminary plans and design for a physical suicide barrier, for accepting the cost estimate of \$2 million, and for directing staff to investigate possible public and private funding sources, and

**BE IT FURTHER RESOLVED**, that the Mental Health Board expresses its gratitude and appreciation to all the San Francisco representatives on the Bridge Board of Directors for their support of the barrier, specifically: Supervisor Tom Ammiano,

Supervisor Bevan Dufty, Maryanne Harrison, Sabrina Hernández, Supervisor Jake McGoldrick, Janet Reilly, Supervisor Gerardo Sandoval, Leah Shahum, and Stanley Smith, and

BE IT FURTHER RESOLVED, that the Mental Health Board expresses its gratitude and appreciation to the Metropolitan Transportation Commission for setting aside \$1.6 million for the barrier planning and design, and

BE IT FURTHER RESOLVED, that the Mental Health Board urges the Golden Gate Bridge Board of Directors to proceed with implementation as quickly as possible, and that the Mental Health Board urges the City and County of San Francisco to contribute to the \$400,000 local match for planning and design.

(Passed with Idell Wilson opposed.)

#### PROPOSED RESOLUTION (MHB-2005-14): SUPPORTING THE HEALTH COMMISSION REGARDING BUDGET CUTS

WHEREAS, major cuts have been proposed to the budget of Community Behavioral Health Services, and

WHEREAS, these cuts would have meant the loss of key programs and staff, and

WHEREAS, these programs would be very difficult to restart, and

WHEREAS, there is an unquestionable need for these programs, and

WHEREAS, the Mental Health Board has taken a consistent position over the past years recommending strongly that the City and County of San Francisco respond to the continual budget crises with revenue strategies rather than cut strategies, and

WHEREAS, the Mental Health Board believes that the budget for Community Behavioral Health Services should be enhanced rather than cut, and

WHEREAS, the Health Commission voted on April 7, 2005, not to accept the proposed cuts to Community Behavioral Health Services, now therefore

BE IT RESOLVED, that the Mental Health Board of San Francisco declares its support for the Health Commission's position on the budget and expresses its gratitude and appreciation to the Health Commission, and

BE IT FURTHER RESOLVED, the Mental Health Board urges Dr. Katz, as Director of Public Health, to do everything in his power to not make cuts to direct services.

(Passed unanimously.)

Ms. Shaffer: The organization Support for Families of Children with Disabilities does the resource conference every year and it was phenomenal. I can't say enough good things about that agency. One day we might want to make a resolution about that.



Mr. Medema: I want to give a brief report on the Prop 63 Committee on Older Adults, which I co-chair. At our first meeting, we filled 18 pages of flip chart paper with notes on ideas for services. Tomorrow night will be the first task force meeting. I encourage MHB members who are not part of the Task Force to come to Task Force meetings and subcommittee meetings.

Dr. Turner: Congratulations to Michael for serving as Co-Chair.

## **5.0 NEW BUSINESS**

Dr. Moses: I want to follow up about Dr. Katz. I'd like to see us send a friendly invitation to Dr. Katz to attend our meeting. And I think he should see our friendly faces. I think we should also invite the President of the Health Commission.

Ms. Wilson: I'm doing a resource fair for people with disabilities at City College on May 17th.

Ms. Shaffer: I had an opportunity to meet with SFUSD special education staff and talked with them about coming to the MHB to make a presentation.

## **6.0 PUBLIC COMMENT**

Juan: I do have Medicare/Medi-Cal eligibility. In 2003 Dr. Cabaj wrote a letter detrailing a policy that veterans are not required to seek services at the Veterans Administration. In 2005, Dr. Cabaj, wrote another letter stating the same thing. I was asked to leave Mission Mental Health Clinic even though I have Medi-Cal/Medicare. I do not receive dental or psychiatric services at the VA. Most of these agencies are turning veterans away. The policy about veterans is not being enforced. I'm working with Swords to Plowshares and letting people know that this policy is not being followed. I'm not fighting the City, I just want to make sure veterans are getting services.

Mr. Luebke: Tonight's my last night. Lisa is taking my seat. I appreciate the opportunity to get more connected to my community. I'm going to be staying in San Francisco instead of moving to southern California.

## **7.0 ADJOURNMENT**

There being no further business, the meeting was adjourned at 9:00 p.m.







## SAN FRANCISCO MENTAL HEALTH BOARD

Gavin Newsom  
Mayor

1380 Howard Street, Suite 510  
San Francisco, CA 94103  
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### MEETING OF THE MENTAL HEALTH BOARD

Wednesday, May 11, 2005  
1380 Howard, Room 537  
6:30 p.m.

DOCUMENTS DEPT.

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### AGENDA

Public comments will be taken for each agenda item.

#### 1.0 CALL TO ORDER AND CONSENT CALENDAR (5 minutes)

For discussion and proposed action.

05-12-15A9945 - CIV

##### 1.1 Call to Order and Announcements from the Chair

##### 1.2 Consent Calendar

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of April 13, 2005, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of May 11, 2005 to the following members:

#### 2.0 PRESENTATION: HOUSING FIRST POLICY AND RESIDENTIAL TREATMENT (50 minutes)

Jonathan Vernick, Executive Director, Baker Places

Speaker to be announced from the Mayor's Office, Project Connect

Speaker to be announced from the SF Police Department Operation Outreach

##### 2.1 Discussion of Possible Future Actions Related to Presentation (10 minutes)

#### 3.0 DIRECTORS REPORTS (30 minutes)

For discussion.

##### 3.1 Report from the Director of Community Behavioral Health Services

A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

##### 3.2 Report from the Executive Director of the Mental Health Board

A report including updates and announcements regarding the activities and operations of the Board.

Special discussion of issues regarding the Access program for CBHS.

#### **4.0 MENTAL HEALTH BOARD COMMITTEES ( 15 minutes)**

For discussion and proposed action

##### **4.1 Report of the Chair of the Board and Executive Committee**

The Chair will report discussions and actions of Executive Committee.

Discussion of budget policy and strategy.

Letter to Mayor Newsom and Supervisor Bevan Dufty commending them for creating the Methamphetamine Task Force.

4.1.a Report from the Board Members on meetings and conferences attended.

4.1.b PROPOSED ACTION: Resolution commending the Mental Health Association for their Anti-Stigma Conference on May 12.

#### **5.0 NEW BUSINESS (5 minutes)**

Suggestions for future agenda items or issues the Board might consider looking into.

#### **6.0 PUBLIC COMMENT (5 minutes)**

This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

#### **7.0 ADJOURNMENT**

##### **DISABILITY ACCESS**

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD). Five days notice before the meeting will help to ensure the presence of an ASL interpreter or sound enhancement system. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and 14 Mission. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley which runs on the opposite side of the building from 10th Street.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

## **POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES**

The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

## **KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE**

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Donna Hall  
Sunshine Ordinance Task Force  
City Hall, Room 244  
1 Dr. Carlton B. Goodlett Place  
San Francisco, CA 94102-4689  
Telephone: (415)554-7724  
Fax: 4(15) 554-5163  
E-mail: [Donna\\_Hall@ci.sf.ca.us](mailto:Donna_Hall@ci.sf.ca.us)

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from Ms. Hall, or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: [www.sfgov.org/sunshine.htm](http://www.sfgov.org/sunshine.htm)

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: [www.sfgov.org/mental\\_health](http://www.sfgov.org/mental_health). You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

## **Lobbyist Registration and Reporting Requirements**

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site [www.sfgov.org/ethics](http://www.sfgov.org/ethics).



SAN FRANCISCO MENTAL HEALTH BOARD



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**MENTAL HEALTH BOARD  
ATTACHMENT A  
May 11, 2005**

**PROPOSED RESOLUTION (MHB-2005-xx): COMMENDING THE MAY 12TH ANTI-STIGMA CONFERENCE**

WHEREAS, many people with mental illness have said, "The stigma against mental illness is worse than the illness itself," and

WHEREAS, stigma continues to do significant damage to the lives of people with mental illness and their families and loved ones, and

WHEREAS, the historic Mental Health Services Act (Proposition 63), passed by the voters of California in 2004, mandates new programming for the: 1) Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services, and 2) Reduction in discrimination against people with mental illness, and

WHEREAS, the Mental Health Association of San Francisco is presenting a conference titled, "Beat the Stigma: Changing Public Perception of Mental Illness," featuring a national expert on the issue, and

WHEREAS, this conference is open to mental health clients, family members, service providers, and all interested members of the community, and

WHEREAS, the timing of this conference dovetails with the planning for the implementation of the Mental Health Services Act and its mandate for anti-stigma programming, now therefore

BE IT RESOLVED, that the Mental Health Board of San Francisco commends the Mental Health Association of San Francisco for providing its "Beat the Stigma" conference for San Francisco, and

BE IT FURTHER RESOLVED, that the Mental Health Board of San Francisco commends the Training Committee of Community Behavioral Health Services for partnering with the Mental Health Association and co-sponsoring this conference.







## **SAN FRANCISCO MENTAL HEALTH BOARD**

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### **MENTAL HEALTH BOARD ATTACHMENT B May 11, 2005**

#### **RESOLUTION (MHB-2005-xx): SAN FRANCISCO'S BUDGET CRISIS**

WHEREAS, San Francisco is facing significant budget cuts to public health and human services, and

WHEREAS, Community Behavioral Health Services has spent years creating a strategic, cost-effective system of care with a focus on community-based treatment replacing institutional care, which meets the Bronzan-McCorquodale guidelines as detailed and mandated in the Welfare and Institutions code for the State of California, and

WHEREAS, significant mid-year cuts have already been made, diminishing and jeopardizing the Single Standard of Care, despite the fact that the Single Standard of Care has proven to be a successful strategy in helping to reduce the numbers of homeless and the need for institutional treatment, and despite the fact that the Single Standard of Care is a policy of the Department of Public Health as determined by the Health Commission, and is a policy as well of the Mental Health Board, and

WHEREAS, even though mental health and substance abuse services are currently being protected from the most serious immediate cuts by being placed on the contingency list for cuts instead of the base budget list, still it is the case that cuts to other public health services such as primary care, will have a major impact on clients of Community Behavioral Health Services and other residents of San Francisco in need of services, and

WHEREAS, cuts to community-based programs mean that many clients of the public health system who go unserved will end up in very expensive institutional care—Psychiatric Emergency Services, inpatient units at San Francisco General Hospital, the county jail—or will end up homeless and out on the streets, with the possible ironic outcome that the cuts may cost the City more than they save, and

WHEREAS, the Mental Health Board believes that a strong and effective public health system directly benefits all neighborhoods and economic sectors of the community; and

WHEREAS, the Mental Health Board believes that our community has a moral and ethical duty to care for those people who are ill, suffering, in trouble, and in need, now, therefore,

**BE IT RESOLVED**, that the Mental Health Board urges the City and County of San Francisco to respond to the crisis in funding for all public health and human services with



a comprehensive revenue strategy, not just a cutting strategy, and to do a thorough and comprehensive review of all the City's revenue sources, closing loopholes, and bringing fees into alignment with what they are in other major American cities, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco do everything in its power to protect the long-term investment it has made in its services so permanent damage is not done, and to take all necessary steps to preserve and defend the vital, state-of-the art services the City has developed through years of intensive effort, and

BE IT FURTHER RESOLVED, that the Mental Health Board strongly recommends that the City and County of San Francisco use a prevention operating system for its services instead of a crisis operating system, by protecting community programs which prevent the need for institutionalization of clients, and especially by following the principles of wellness and recovery, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that with regard to mental health services, the City and County of San Francisco, in this short-term period of a few months until funding from the Mental Health Services Act begins to arrive from the State of California, to be strategic and make sure that crucial programs are not lost in the meantime, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco do everything in its power to protect the sustainability of the community-based nonprofit organizations which deliver such a large percentage of its public health services, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco continue to lobby strongly for parity in mental health care so that the public mental health system is not having to take clients who should rightly be covered by private insurance companies through private employers, and continue to lobby for health coverage for all citizens, thereby lessening the burden on municipal public health systems due to the numbers of uninsured or underinsured working citizens, and

BE IT FURTHER RESOLVED, that the Mental Health Board commends Supervisor Tom Ammiano and the entire the Board of Supervisors in 2004 for their leadership on the passage of the Mental Health Services Act (Proposition 63), which will fund the transformation of the mental health system, now and for years to come, and

BE IT FURTHER RESOLVED, that the Mental Health Board commends the members of the Board of Supervisors who gave their strong support to the local revenue measures on the ballot in November 2004, and

BE IT FURTHER RESOLVED, that the Mental Health Board commends Mayor Gavin Newsom for the leadership he took with regard to the passage of the Mental Health Services Act (Proposition 63), for his strong support of revenue measures that were on the ballot in November 2004, and for his current efforts to preserve the strategic system of programs that make up Community Behavioral Health Services, and



BE IT FURTHER RESOLVED, that the Mental Health Board commends the Health Commission for voting to protect mental health services and substance abuse services, given that for most of the clients of our system, there is nowhere else to turn for services except to our system.



# SAN FRANCISCO MENTAL HEALTH BOARD



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## **UNADOPTED MINUTES**

**Mental Health Board**  
Wednesday, May 11, 2005  
1380 Howard Street, Room 537  
San Francisco, CA 94103  
6:30 p.m.

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**BOARD MEMBERS PRESENT:** Rebecca Turner, Ph.D. (Chair); Benito Casados; Bob Douglas, J.D.; Supervisor Bevan Dufty; James L. McGhee; Michael Medema; Toyé Moses, Ph.D., M.P.H.; Dorothy Shaffer, R.N., N.P., M.S.N.; Jagruti Shukla, M.D., M.P.H.; Kate Walker; Lisa Williams; Idell Wilson.

**BOARD MEMBERS ON LEAVE:** LaVaughn Kellum-King; chance martin.

**BOARD MEMBERS ABSENT:** none.

### **PRESENTERS:**

Jonathan Vernick, Executive Director, Baker Places

David Nakanishi, MPH, LCSW, Director of the San Francisco Homeless Outreach Team

**OTHERS PRESENT:** David Pilpel; Emeric Kalman; James Greenblatt; Ruth Gravitt, R.N. (Mental Health Association - San Francisco); Alexander Bingham (Golden State Psychological Health Center); Helynnna Brooke (MHB Executive Director); Rich Snowden (MHB Administrator).

### **1.0 CALL TO ORDER AND CONSENT CALENDAR**

The meeting was called to order at 6:38 p.m. by Rebecca Turner, Chair.

We want to begin the meeting with a moment of silence for Bruce Franks, a caseworker at Conard House who was tragically killed on Monday morning at work.

Next I'd like to ask the new CBHS Medical Director, Aaron Chapman, to introduce himself.

Dr. Chapman: I've been here in this position for about two months. I've been with the City and County of San Francisco for eight years. I was at the South of Market Mental Health and the Mission Castro center. I'm still holding on at Mission-Castro because they don't currently have a psychiatrist there.



My focus is on integration of mental health and primary care. I have worked in that area, as well as integrating substance abuse with mental health. I'm now moving from the clinic perspective to the system perspective. I work here at 1380 Howard. If you need to speak to me, call me here. Thanks for inviting me to stop by.

Dr. Turner: We have two new Board members tonight, and we're really happy that they've been appointed:

Jagruti Shukla is a family physician appointed to a Family Member Seat by Supervisor Jake McGoldrick.

James McGhee was appointed to a Public Interest Seat by Supervisor and President of the Board, Aaron Peskin.

Dr. Shukla: I've just recently moved here from Los Angeles. My interest in joining the Board is from two different paths as a family member. I have a brother who is diagnosed with schizophrenia, and who is in an inpatient setting right now. This has been a long and difficult involvement for our family. Another interest I have in mental health is as a physician. Until recently I was working at Mission Neighborhood Health Center, where we saw a lot of patients struggling with mental health issues and homelessness. Now I'm the Medical Director at a primary care clinic in San Mateo, under the Department of Public Health there. A lot of mental health issues come up on a daily basis.

James McGhee: I met with Aaron on several occasions and we talked about boards and commissions, and the Mental Health Board is one that is close to me. I also have a family member and close friends who suffer from mental illness, and I've seen how it has affected their families and how it has affected me. One of my friends was in my wedding and I've been knowing him for a long time. I also sit on the Board of Psychology for the State of California. I come from a business background and have a management consultant firm. I do studies in health care as well as other industries. I feel really compelled to be here on the Board. So when Aaron asked me to do this, I said, "Not a problem."

## **Consent Calendar**

**1.2.a RESOLUTION (MHB-2005-15):** Be it resolved that the minutes of the Mental Health Board meeting of April 13, 2005, be approved as submitted.

**1.2.b RESOLUTION (MHB-2005-16):** Be it resolved that the Mental Health Board grant leaves of absence for the meeting of May 11, 2005, to the following members: LaVaughn Kellum King, chance martin.

(Passed unanimously.)

## **RESOLUTION (MHB-2005-17): COMMENDING THE MAY 12TH ANTI-STIGMA CONFERENCE**

**WHEREAS**, many people with mental illness have said, “The stigma against mental illness is worse than the illness itself,” and

**WHEREAS**, stigma continues to do significant damage to the lives of people with mental illness and their families and loved ones, and

**WHEREAS**, the historic Mental Health Services Act (Proposition 63), passed by the voters of California in 2004, mandates new programming for the: 1) Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services, and 2) Reduction in discrimination against people with mental illness, and

**WHEREAS**, the Mental Health Association of San Francisco is presenting a conference titled, “Beat the Stigma: Changing Public Perception of Mental Illness,” featuring a national expert on the issue, and

**WHEREAS**, this conference is open to mental health clients, family members, service providers, and all interested members of the community, and

**WHEREAS**, the timing of this conference dovetails with the planning for the implementation of the Mental Health Services Act and its mandate for anti-stigma programming, now therefore

**BE IT RESOLVED**, that the Mental Health Board of San Francisco commends the Mental Health Association of San Francisco for providing its “Beat the Stigma” conference for San Francisco, and

**BE IT FURTHER RESOLVED**, that the Mental Health Board of San Francisco commends the Training Committee of Community Behavioral Health Services for partnering with the Mental Health Association and co-sponsoring this conference.

### **4.1.c RESOLUTION (MHB-2005-18): SAN FRANCISCO’S BUDGET CRISIS**

**WHEREAS**, San Francisco is facing significant budget cuts to public health and human services, and

**WHEREAS**, Community Behavioral Health Services has spent years creating a strategic, cost-effective system of care with a focus on community-based treatment replacing institutional care, which meets the Bronzan-McCorquodale guidelines as detailed and mandated in the Welfare and Institutions code for the State of California, and

**WHEREAS**, significant mid-year cuts have already been made, diminishing and jeopardizing the Single Standard of Care, despite the fact that the Single Standard of Care has proven to be a successful strategy in helping to reduce the numbers of

homeless and the need for institutional treatment, and despite the fact that the Single Standard of Care is a policy of the Department of Public Health as determined by the Health Commission, and is a policy as well of the Mental Health Board, and

WHEREAS, even though mental health and substance abuse services are currently being protected from the most serious immediate cuts by being placed on the contingency list for cuts instead of the base budget list, still it is the case that cuts to other public health services such as primary care, will have a major impact on clients of Community Behavioral Health Services and other residents of San Francisco in need of services, and

WHEREAS, cuts to community-based programs mean that many clients of the public health system who go unserved will end up in very expensive institutional care—Psychiatric Emergency Services, inpatient units at San Francisco General Hospital, the county jail—or will end up homeless and out on the streets, with the possible ironic outcome that the cuts may cost the City more than they save, and

WHEREAS, the Mental Health Board believes that a strong and effective public health system directly benefits all neighborhoods and economic sectors of the community; and

WHEREAS, the Mental Health Board believes that our community has a moral and ethical duty to care for those people who are ill, suffering, in trouble, and in need, now, therefore,

BE IT RESOLVED, that the Mental Health Board urges the City and County of San Francisco to respond to the crisis in funding for all public health and human services with a comprehensive revenue strategy, not just a cutting strategy, and to do a thorough and comprehensive review of all the City's revenue sources, closing loopholes, and bringing fees into alignment with what they are in other major American cities, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco do everything in its power to protect the long-term investment it has made in its services so permanent damage is not done, and to take all necessary steps to preserve and defend the vital, state-of-the-art services the City has developed through years of intensive effort, and

BE IT FURTHER RESOLVED, that the Mental Health Board strongly recommends that the City and County of San Francisco use a prevention operating system for its services instead of a crisis operating system, by protecting community programs which prevent the need for institutionalization of clients, and especially by following the principles of wellness and recovery, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that with regard to mental health services, the City and County of San Francisco, in this short-term period of a few months until funding from the Mental Health Services Act

begins to arrive from the State of California, to be strategic and make sure that crucial programs are not lost in the meantime, and

**BE IT FURTHER RESOLVED**, that the Mental Health Board recommends that the City and County of San Francisco do everything in its power to protect the sustainability of the community-based nonprofit organizations which deliver such a large percentage of its public health services, and

**BE IT FURTHER RESOLVED**, that the Mental Health Board recommends that the City and County of San Francisco continue to lobby strongly for parity in mental health care so that the public mental health system is not having to take clients who should rightly be covered by private insurance companies through private employers, and continue to lobby for health coverage for all citizens, thereby lessening the burden on municipal public health systems due to the numbers of uninsured or underinsured working citizens, and

**BE IT FURTHER RESOLVED**, that the Mental Health Board commends Supervisor Tom Ammiano and the entire the Board of Supervisors in 2004 for their leadership on the passage of the Mental Health Services Act (Proposition 63), which will fund the transformation of the mental health system, now and for years to come, and

**BE IT FURTHER RESOLVED**, that the Mental Health Board commends the members of the Board of Supervisors who gave their strong support to the local revenue measures on the ballot in November 2004, and

**BE IT FURTHER RESOLVED**, that the Mental Health Board commends and thanks the Budget and Finance Committee of the Board of Supervisors for the letter they sent to Mayor Gavin Newsom on April 28, 2005, regarding their policy and program priorities, and that the Mental Health Board adds its support and endorsement to the macro goals the Committee detailed, and to the specific priorities they set with regard to public health services, and

**BE IT FURTHER RESOLVED**, that the Mental Health Board commends Mayor Gavin Newsom for the leadership he took with regard to the passage of the Mental Health Services Act (Proposition 63), for his strong support of revenue measures that were on the ballot in November 2004, and for his current efforts to preserve the strategic system of programs that make up Community Behavioral Health Services, and

**BE IT FURTHER RESOLVED**, that the Mental Health Board commends the Health Commission for voting to protect mental health services and substance abuse services, given that for most of the clients of our system, there is nowhere else to turn for services except to our system.

## 2.0 PRESENTATION: HOUSING FIRST POLICY AND RESIDENTIAL TREATMENT

Mr. Nakanishi: Thank you for inviting both of us tonight. I wanted to make a clarification. I am the Director of the San Francisco Homeless Outreach team. While we are extremely involved in Project Connect, that is actually a separate program.

The Outreach Team is doing outreach on a daily basis. Project Connect happens every other month at this point. It's a one-day mass mobilization, which we are part of.

I want to start with questions, so I can focus on what you need to know.

Mr. Kalman: Is this a state mandated undertaking?

Mr. Nakanishi: No, I'll speak to that.

Dr. Moses: Can you address the demographics, the ethnicity, and the stigma attached to homelessness?

Dr. Turner: What about effectiveness? Can you give us any data that shows effectiveness of the implementation of the Mayor's policy?

Mr. Nakanishi: I'm more than happy to come back if we don't get through everything tonight. I don't have all the data with me tonight. But I can come back and bring that with me.

The San Francisco Homeless Outreach Team is part of Community Behavioral Health Services and I report directly to Barbara Garcia.

May 11th is our one year anniversary. The mandate for our program came from Mayor Gavin Newsom. There used to be various outreach teams out of the Department of Public Health, such as the Hope Team, the MOST Team, and the Homeless Death Prevention Team. All of them got disbanded about 3-4 years ago. The Mayor has a key focus on dealing with the homeless. He mandated DPH and DHS to re-constitute an outreach team. We started a week after Care Not Cash was started.

We put ten outreach workers on the street. We started 6 days a week 24 hours a day. But we've had to cut back and now operate 5 a.m. to 1 a.m. Monday through Friday.

The Team includes formerly homeless people. The psychiatric social workers and the psychiatrist do treatment on the street. We deal with mental health, substance abuse, and major medical issues. The target area is the center of the city, mainly the Tenderloin, which has the highest concentration of homeless folks.

Though we're basically in the Tenderloin, we also work with Operation Outreach, a special detail out of the SFPD and the paramedic captain, focusing on high 911 users.

We certainly operate from a housing-first model. We have 109 stabilization hotel rooms. The client does not pay rent. They get extended week by week as long as they are

working with a case manager. This gives them a chance to get used to being indoors. We know where they are so we can help them follow up with benefits and treatments with the goal of getting them into permanent housing.

We could use more staff and more units.

The demographics pretty much match what we find in the Tenderloin. Most of the resources available tend to be for individuals and adults. We are targeting the chronic street homeless, the visible homeless. The folks in the Tenderloin tend to be single. There are more males than females. They are Caucasian and African American. There are very few Asians and Latinos. There are some Native Americans. It's quite a range of people. The vast majority have multiple diagnoses.

Dr. Moses: I think a lot of people feel ashamed of being homeless. Do you run into people like that, people who are in denial?

Mr. Nakanishi: Most of the chronic homeless are very clear about being homeless. People tell us they are choosing to be on the street and refuse housing. There are different reasons for that. Then there are people who feel the stigma or feel hopeless about changing their situation. Or feel like housing won't work without treatment. Part of our work is developing a relationship with the client, to help them see that there is hope, that they can get hooked up with treatment. We will walk them through treatment, and help them if they run into providers who throw up their own stigma in the way.

In terms of the effectiveness of the Mayor's policy, we are often asked about Care Not Cash and Project Connect. In a way the jury is still out. Until we get another year under our belt, we won't be able to determine effectiveness. We have housed 800 people under Care Not Cash. But the effectiveness of getting people into housing requires ongoing support. We stay in touch with them; we make sure when they get to permanent housing they get services so they can sustain in that housing.

In general where the Mayor is going is very positive. I've been around DPH for ten years. This is an administration that is political, which I think it needs to be, but this is a Mayor who really wants to help the homeless. He wants to do things differently. He's bringing in new money and new funding sources to the city. He's coordinating citywide agencies that didn't necessarily work together in the past. We ride with SFPD, we get referrals from them. We work with paramedics, we work with DHS, we work with nonprofits. We're organizing a citywide discharge group so wherever a homeless person lands, they do not get discharged to the street.

This is being driven by the Mayor, and then people like Barbara Garcia are able to take advantage of this political push to make very positive changes. I'm very optimistic about what this administration is doing and where things are going. This is a Mayor who will look at what works and what doesn't and will ask how can we make it different if things are not working. He has listened to service providers. Which is different from the past. The jury is still out, but we have been very successful in housing some very ill and very difficult clients in a very short period of time.



Mr. Douglas: What about homeless families who lose their kids? Is there anything you can do to help them?

Mr. Nakanishi: The demographic we tend to deal with is single adults. Part of my role is to drive policy and changes in the system. We deal with families and family reunification and transitional youth. They are not the visible homeless so they are not our mandate, but we do deal with them. And Project Connect works with them. There needs to be more family housing, more couples housing. There are often people on the street who band together and look after each other, and they want to be housed together. Things move slowly, but there is a lot going on to address the special populations.

Ms. Walker: You have 109 units. What happens when the 110th person comes along? How many people could you serve if you had more rooms? How many more rooms could you fill?

Mr. Nakanishi: It's really about permanent housing. If you gave me 1000 temporary rooms I'd fill them. But the push needs to be on much more permanent housing. That's what we need the most. If there's permanent housing then I'll fill it. There's certainly a need out there. You give me 1,000 units, and I'll have them filled in less than a week, but what do we do from there? We're trying to juggle as best we can.

Ms. Walker: Wouldn't it be easier to get a couple more hotels? At least they'd have a place to stay. Even if it's just temporary housing, at least it's a step up. Why not put more resources into getting people off the street?

Mr. Nakanishi: There are plenty of people who need permanent housing. If you had a stock of money, I'd say, put it all into permanent housing. That's the way to do this. If you give me 1,000 permanent units, I'd fill them within a month.

Ms. Shaffer: What about consolidation, so there is no duplicating of services?

Mr. Nakanishi: We're moving in that direction. We are trying to have one database, so we are not duplicating services with the same clients. We find the experts that are already there. First go talk to existing providers in the neighborhoods. We find out what people are doing, so we don't duplicate but add onto what's already going on in a community.

Ms. Shaffer: What's the age range?

Mr. Nakanishi: We deal with pregnant women, people with newborns, families, and the oldest person we're working with is 92. We work with the whole age range. I was the director of the Transitional Youth Program, and I worked in children's services at CBHS. I have also worked in acute settings. So I'm very versed in the range of clients.

Ms. Shaffer: What are you looking at to check the validity of outcomes?

Mr. Nakanishi: I have no administrative support, so all the data collection is done by me. We're hoping to get a database up in the next month. I'm preparing an annual



report. We are looking at who we've housed, what kind of services we've linked people to. We're looking at the length of stay in temporary housing. We're still talking about what are the best outcome measures to look at, but housing is clearly one of the best indicators.

We've been able to house clients who people said, "You're never going to get them off the street." Lots of people who you might see sitting out on the street panhandling are now housed.

Mr. McGhee: What is the period of transition that people stay in temporary housing? What percentage is still on street that need this type of housing?

Mr. Nakanishi: The original numbers we were going on for chronic homeless is 3,000 for the city. The average stay in stabilization, was about 2-3 months. The contrast I would put out is Philadelphia, which was one of the models the Mayor was looking at. The average time from off the street into housing was two years. For some of our people it will take a year or two to do that. But we're finding some very good effectiveness with the housing-first model right off the bat. But partly because DPH has been receptive to us. We already have a fairly integrated system.

Dr. Moses: I want to commend the Mayor for doing his very very best with this. I want to commend you for wearing so many hats, as change agent and social worker. I want to follow up on the demographic aspect. It appears that most of your clients are in the Tenderloin. But a lot of people are migrating to the Bayview now, being chased out from downtown. Is there any way to reach them and make sure they know what services are available downtown?

Mr. Nakanishi: The reality is that it's not just the Bayview. The homeless are getting pushed into many areas of the city that have not experienced that before. We are regularly out in the Bayview, and we are addressing two encampments out there. One of the methadone treatment programs we work with is out in the Bayview. We're aware that people are getting pushed out. But at this point there are only eight people out on the street. The plan is to double the team to 20 members in the next year.

Dr. Moses: Is there any suggestion on how to solve the revolving door syndrome?

Mr. Nakanishi: Yes and no. My experience is that the best way to help people is really a case-by-case basis. There are different factors for individuals. The challenge is to make sure you coordinate with everyone, and establish a relationship with the client. If you take a shotgun approach, you're going to affect some, but not everybody. How do you address individuals as a system? That's a challenge, but I think you can do this.

Mr. Vernick: I'm the Executive Director of Baker Places, which is one of the nonprofit organizations that has been providing services in San Francisco for 40 years and we provide residential treatment services. I've worked there for 23 years, as Program Director, Clinical Director, and now Executive Director since 1990.

I'd like to describe what we do, and we do a lot of different things, from residential treatment services to case management to services for people in hotels. We run and operate some hotels.

In terms of the budget, all nine residential transition treatment programs were proposed for elimination. But for the first time that I can remember, the Health Commission turned around the direction of the Health Director and said, "We don't think this is a good idea. We don't think it's a good idea to eliminate a modality that has proven itself over the years." So the Health Commission sent forward a different set of recommendations to the Mayor and the Mayor supported that recommendation.

There is a distinction between treatment and housing-first. Probably David and I agree on most of these things. But when the Health Director put out the rationale for the budget cut, he put out articles that were published by people who developed the housing-first model in New York. That model does not have the support services. And the articles were written by housing-first operator in New York. He found that residential treatment did not have positive outcomes, but housing-first did. From my point of view, those articles were biased. Mitch Katz used those articles as part of the budget discussion and a storm ensued.

Rather than make a false dichotomy who's mentally ill and who has a substance abuse problem, we see that many people have concomitant problems. On any given day, they can find themselves in one part of the system or the other. Sometimes they can't get to the right part of the system. Some substance abuse programs are not fond of working with mental health people and reject them, and that's just a simple reality. We have Grove Street, the only residential dual diagnosis program in the system.

One day in SFGH costs \$1,400. Baker Places costs \$120-300 a day.

All our programs are intentional communities. They are small programs based in neighborhoods. We have to go through city planning and neighborhood approval. We have to address the issue of stigma. We inevitably win our conditional use fights. The most persuasive way to convince a neighborhood, that people with mental health and substance abuse and substance abuse are not going to do any harm is to have one of these program in your neighborhood. Then the neighbors become your best advocate. I have many examples of neighbors asking us in. For example on San Jose Avenue, the next door neighbor rallied all the neighbors years ago to oppose us. We won the hearing. We were there for a couple of years. The grown son of the neighbor moved out and then the neighbor came over and said he'd like to sublet the room to a graduate of our program.

We saw a change about 15 years ago, with more clients spending more time on the street, and with increasingly long periods of homelessness. In the old days, working with mental health problems, when clients used drugs, we'd say they were self-medicating. Mental health workers were very naive about that. Those clients were addicted. We developed some dual diagnosis programs out of our need to find better ways to treat people who were indeed drug addicted.

One of the first programs we created was the Grove Street program to respond to people with serious mental health and serious substance abuse issues. They would show up at SFGH diversion, but couldn't access the next level of care. There was nowhere in the mental health system for them to go, and substance abuse programs wouldn't touch them because of their mental health issues. We have a long waiting list there.

Then the AIDS epidemic began to occur. We responded to people with AIDS and substance abuse issues by setting up Ferguson Place.

Along the way we developed a continuum of care so clients who were making progress would have a safe place to go. We saw that clients did not have enough money or the kind of credit history they needed to rent an apartment. So then we created a co-op system. We'd lease up small apartments and flats. We'd the pay first and last months rent and we created a loan system. We use the peer support model. The clients would select roommates. We'd provide support to them. Four to five people were in a group. If people ran into problems, they could go back to residential treatment for short time, then back to the co-op so they didn't suffer the loss of their housing.

I agree with David's comments about Barbara Garcia. She approached me one day, and asked if we could we create some detox beds at one of our programs. I said, "I don't think that will work to just convert a couple beds, but I think we could do a whole program." So we dreamed up this program and there was nothing like it before. There was no such license that existed to provide this service outside the hospital.

If nurses were working under physicians orders, then it would be okay. The County would serve as the physician. Ours was the first medically-managed detox unit in California. We now have two of them. These clients are probably the sickest people in the system who will not enter a hospital.

We apply a social rehabilitation model. We use a medical model in the first five days of detox. But then try to get people to participate in their care, participate in the community, determine where they want to go, become a responsible member of that community. We don't discharge people for a relapse. Our policies have changed significantly over the years. The consequences of discharging people to the streets are so grave, we try to keep them in the program. We work with the direct access to housing programs. We operate several hotels with support services.

We're probably the most blended, integrated nonprofit in the city.

Next I want to talk about the issue of housing-first and treatment. I think it's important to understand a couple issues. Baker Places, Progress Foundation, and Conard House (which has one residential treatment program) are the three agencies which make up the total array of the residential treatment in San Francisco. That's it.

One of our requirements is that we have as an outcome measure, over 60% of of our clients have to show reduction in hospitalization for six months post discharge. We look at the period of 6 months before the client's entry into program, and count the number of days in the hospital. Once the client is out of our program, we compare the initial

figure to the hospital days in that post-discharge six months, and we want to see clients reduce their use of the hospital by over 60%. Our figures at Baker Places, at minimum, show a reduction by over 70% for the past five years. That alone is a pretty good number. You can argue it can't get much better than that, because at what point is the measure no longer the result of our treatment, and now the result of whoever the new provider is.

The criticism in the housing-first article was that residential treatment doesn't have impact after three months. That's not so in San Francisco. De-institutionalization was a failure. No, that was not a failure. They closed the mental institutions. What was a failure was a failure of the federal government to fund the community programs, and everyone knows that. So to just call it a failure is really a shallow analysis and erroneous.

It's important that we not discontinue support for treatment. We worked a number of years ago with people from the Corporation for Supportive Housing, to create an array of services, and a model of care for people living in hotels throughout the city. The Tom Waddell Clinic would have doctors and nurses going from clinics to treat people in hotels.

If someone needs detox they can't do that in the hotel. If they are decompensating, they can take care of that in the hotel.

Dr. Moses: Thank you for making sure that Baker Places is still alive. To see it progressing and expanding is great. How do you handle the issue of people shuffling between programs?

Mr. Vernick: Over the years our attitude has changed with the changes in the client population. The nature of the problems the clients are dealing with these days are such that I have no objections to seeing clients enter programs again and again. With certain people you have to ask the question when is enough enough. But in general we have a lot of return folks, that's what we're going to see. That may be what it takes.

Dr. Shukla: In terms of all these modalities of care which do you see are most wanting of resources?

Mr. Vernick: I think one of the concerns I have is that one of the problems of care, is that it's an acute-run system of care. I would say that the system of care should be on a transitional residential level. We don't need more acute care. The lower cost programs where people are able to be there for a longer period of time are the most effective.

Mr. Nakanishi: I would support that. Since there is such a paucity of resources for substance abuse services, we need the detox level. I got the Windsor program up and running. Drug treatment and residential treatment is very different from supportive housing, so I'd agree that longer term residential treatment is where the key is, though we need the whole continuum.

Supervisor Dufty: I'm working on a project with the Castro Country Club.

Mr. Vernick: The Castro Country Club is a clean and sober coffee house in the Castro, which was started over 20 years ago by Joe Healey. Subsequently Joe became an employee of Baker Places. Then he became a Catholic priest and gave us the Castro Country Club. Over time, the manager of the Club wasn't doing that well and it was becoming more expensive to run. Our budget got tight, so I decided one day that we couldn't continue to support it financially. I think they're going to form their own nonprofit organization. In the meantime, we continue to run it.

Supervisor Dufty: I'm working with them on a renovation.

Mr. Vernick: They are very thankful to you.

### **3.0 DIRECTORS REPORTS**

#### **3.1. Report from the Director of Community Behavioral Health Services**

Dr. Cabaj: I want to highlight a couple things. On Monday there was a horrible incident at Conard House when Bruce Franks, a caseworker there, was shot to death by a former employee. We're working with Conard to help with debriefing clients and staff.

Last month both Edwin and I had to be in Sacramento on your meeting night, so Sai-Ling Chan-Sew filled in for us. I want you to know that she is equally as well-informed as we are about the entire system. She is part of our CBHS Executive Committee.

A couple things came up at the MHB meeting last month about the CBHS Central Access program.

First of all, there's an Access team. And then there's a program called Advanced Access. The Access team is the entry point for people seeking services for the outpatient part of mental health. It's primarily for people with Medi-Cal. In the late 90s, the State decided that each county would be responsible for running a managed care system around mental health services, and as part of that each county had to create an Access team.

In every other county that I'm aware of Access is part of the mental health services. When we did the integration of services in San Francisco, we created a separate Placement Unit. The director of the Placement Unit reported to me for a while, but then Barbara Garcia saw this was such an important piece of the system that she decided that the Placement Unit should be elevated to reporting to her. So that means that Access is no longer part of mental health.

I can't answer your questions about the results of Access, since it's not in my domain any more.

I heard you have concerns which came up in discussions with the State auditors. I had heard that there were a lot of problems with the phones. The phone system just wasn't designed to take the calls Access gets. I did some work with our operations manager to try to get that fixed.

Mr. Casados: They are still having problems. I work at the reception desk here at 1380 Howard. I get calls several times a day that people can't get through to Accesses. I try to transfer calls but they bounce back to the reception desk.

Dr. Cabaj: I really strongly recommended that that be addressed. In terms of the wrong information being given out, when I find out there is an error and it comes to my attention, I certainly let Liz Gray, the director of the Placement Unit, know. As far as I understand it's often an individual who has made an error.

Mr. Casados: Can we make a request to have Liz Gray come and talk with us next month?

Mr. McGhee: Was the prior system working before it was changed?

Dr. Cabaj: I believe it was. I used to meet with the clinical team to go over clinical issues. They could call me anytime. We had more staff originally. At some point, the director was cut. You may have heard that one staff member from Access died a few months ago. Another staff has been out with a major medical issue. I think having fewer staff may have led to some of the problems we have been experiencing.

With regard to Advance Access, this is a client-scheduling model, one I had read about in Los Angeles. I found out they were doing it in other cities and in Canada. Originally it was based on cardiac care clinics. Here we were scheduling people for appointments eight weeks down the road. Then we learned that the average client got re-hospitalized in 30 days because they had no staff to see and couldn't get their medications.

So I wanted to change our system so everyone could get an appointment in the first 24 hours, but I gave a window of up to 48 hours.

This doesn't have anything to do with the Access team other than that the Access team should be able to refer people within 48 hours.

For most clinics, the initial review is done in 24 hours. This is a risk assessment. Some people could wait a little longer, but if they are at a high risk of deteriorating they will be given treatment right then. If they can wait a week or two, we'll do that.

But with people waiting 8 weeks, there was a 60% no-show rate. Now I think Advance Access is working well.

Mr. Casados: Working at the reception desk, we get calls all the time from people who need to see a doctor right away. You refer them to Access.

Dr. Cabaj: Anyone should be able to walk into any clinic and ask to be seen.

Dr. Moses: What about the budget?

Dr. Cabaj: I don't think it's been released yet. I think the Mayor is still working on it. Many of the items we were concerned about were put lower down on the contingency



list. The Mayor, however, doesn't have to follow the contingency budget, so it's important to look at the budget as soon as it's released.

The Director's written report was distributed:

**1. Shooting at Conard Community Service Center.** It is with deep regret and sorrow that we heard this Monday of the shooting at Conard Community Service Center, which claimed the life of Bruce Franks, Conard caseworker. In his work at Conard, Bruce helped many homeless individuals obtain public assistance benefits, and he was well-liked and trusted by everyone. His death is a big loss for all of us. We offer our condolences and sympathies to Bruce's family, co-workers, friends, and loved ones. We also acknowledge and deeply appreciate the swift and heroic actions of Kalifa Coulibaly, Owen Spaulding, and Gregg Wozniak, who risked serious injury and death to prevent the assailant from causing more harm to others.

**2. Participate in Prop 63 Planning in San Francisco.** Everyone is encouraged to attend, and participate in, the planning meetings of the Behavioral Health Innovations Task Force, and its Sub-Committees - which are focused on planning to identify needs, priorities, and strategies, for the use of funds from the Mental Health Services Act (MHSA) to expand and transform San Francisco's mental health services delivery system. The next MHSA Task Force meeting is on Thursday, May 26, 4:00 - 7:00 PM, at the Southeast Facility Commission, 1800 Oakdale.

There is a one-hour public comment period at every Task Force meeting, facilitated by the SF Mental Health Board, to allow members of the public the opportunity to let the Task Force know about the mental health issues that are important for them. We hope to see a lot of you at the next May 26 Task Force meeting.

Aside from the MHSA Task Force meetings, eleven planning Sub-Committees also meet to focus on planning for specific populations and services. These sub-committee meetings are regularly held at the Bill Graham Civic Auditorium, 99 Grove St., throughout the day from 9 AM - 7 PM, on six scheduled meeting dates from April to July 2005.

The schedules of all the meetings - which are all open to the public - as well as the summaries of the results of the meetings, are posted at the San Francisco Department of Public Health website at: <http://www.sfdph.org/Prop63/default.htm>. The meeting schedules are at the following specific websites:

Behavioral Health Innovations Task Force - Schedule of Meetings at  
<http://www.sfdph.org/Prop63/TaskForceMtgSchd.shtml>  
MHSA Planning Sub-Committees - Schedule of Meetings at  
<http://www.sfdph.org/Prop63/SubComMtgSch04072005.pdf>

**3. DPH/CBHS Obtains Cultural Competence Grant.** DPH/CBHS has been awarded a \$121,000 grant to develop and conduct trainings for program managers/analysts and community contractors on the application of the Cultural and Linguistic Appropriate Services (CLAS) standards. The CLAS standards serve as a basis for the development of Cultural Competency Annual Reports required by the Department of Contractors.



**4. Crystal Meth Task Force.** San Francisco has become the first city in the nation to coordinate resources in a citywide effort to deal with crystal methamphetamine. This drug is experiencing a significantly increased impact in the last 18 months. The correlation between crystal use and HIV and STD infections have highlighted the need for a comprehensive response. The Mayor appointed Steven Tierney, Director of HIV Prevention at DPH to Co-Chair this task force with Supervisor Bevan Duffy. Other task force DPH appointees include Jimmy Loyce, Jeff Klausner, MD and Bob Cabaj, MD. The Task Force will develop a plan of action and a set of concrete recommendations to the Mayor within 6 - 10 months.

**5. Annual Meeting of the CBHS Private Provider Network.** The annual meeting of the Private Provider Network (PPN) last April 27 drew approximately 100 people in the largest turn-out since its inception in 1998. The PPN is responsible for serving approximately 3,500 clients a year. Clients referred to the PPN are those who are indigent, or who have Medi-Cal, and are seriously mentally ill. To qualify as PPN providers, clinicians must be licensed, be in good standing with the CA Board of Behavioral Sciences, and have in place malpractice and liability insurance. The PPN provides clients with treatment in the community in private practitioner offices, provider groups, and organizations. Services are prior-authorized through CBHS central access points, such as Central Access, Foster Care Mental Health, Family Mosaic, and AB3632, based on determination of client need. The PPN offers clients a range of clinical specializations and cultural and linguistic diversity. Providers are reimbursed on a fee-for-service basis, often below their standard rates. Due to budget restrictions, rates have not been raised in several years. We honor the dedication, excellent clinical work, and patience that our providers have shown to CBHS, and to our clients. The annual meeting is CBHS' opportunity to update and to thank the PPN providers, and to seek input for improvements. The large showing of providers was heartwarming. Thank you to all who made this happen.

**6. City College Drug & Alcohol Certificate Program.** The Drug & Alcohol Certificate program at City College educates and credentials a culturally diverse student body for careers in the substance abuse field with a 31-unit educational component, and hands-on training in the field through placement in applied internships at community-based agencies. The program has a commitment to provide knowledge of the current trends of drug education, prevention and policy, skills to work with people and systems in clinical settings, and skills to apply research and theory within diverse settings. The program is also committed to the training and advancement of first-level community health professionals working with diverse and underserved communities. The deadline for nominating participants to the program is May 23, 2005, and notification will happen on June 6. For more info, please call Sharon Turner, Associate Director, Drug & Alcohol Studies, City College of San Francisco at (415) 452-5159

**7. CBHS Training Committee - Expanding Substance Abuse Membership.** This year, the SOC Training Committee recruited new members to increase representation from substance abuse services. The new members are Rudy Aguilar, Program Manager, CBHS; Arthur Bosse, MNA, National Council on Alcoholism and other Drug Addictions; Tandy Iles, MPH, Director, Drug and Alcohol Certificate, Health Science Department, Community Health Works; and Ben Eiland, Director of Substance Abuse

Services, Haight Ashbury Free Clinics, Inc. Current members representing CBHS substance abuse services include: Toni Rucker & Kathleen Minioza, CBHS Grants & Research; Lucy Arellano, CBHS QI; and Pandora Boles, Fotep Program, Walden House. David Macias, MPA, HIV Health Services, has also been a member of the committee for several years. The current SOC Training Needs Assessment, which is for CBHS staff to rate and prioritize their choices of trainings in fiscal year 2005-06, includes a category on Substance Abuse Trainings.

### **3.2 Report from the Executive Director of the Mental Health Board**

Ms. Brooke: The 13th Police Crisis Intervention Training took place April 18-21. Bob, Kate, and Benito took part in it. The 14th PCIT will take place June 20-23.

### **4.0 MENTAL HEALTH BOARD COMMITTEES**

Dr. Turner: We're passing out the MHB Bylaws tonight with changes proposed by the Executive Committee. We will be voting on these changes at our next meeting on June 8th.

I've asked Lisa Williams to chair the MHB's Stakeholders Committee. You'll hear more about the meetings of the Committee later. Please consider being a member of that committee. It will focus on developing more input from target stakeholders in the planning process for Prop 63.

#### **Reports on activities of Board members.**

Ms. Walker: I went to a meeting of the Finance Committee of the Board of Supervisors. At the end of the meeting Supervisor Sean Elsbernd announced that I was his appointee to the Mental Health Board. I also heard Bob speak before the Board of Supervisors. He was very clear. He spoke very well, with passion, but without any rancor.

Mr. Douglas: I spoke to the Neighborhood Services Committee of the Board of Supervisors about the elimination of the Single Standard of Care.

Dr. Moses: In September in San Francisco there will be a free presentation by Community Collaboration on Drug Abuse on how to collaborate and write grants. I'll let you know more later.

Dr. Turner: I think the Prop 63 Task Force is going very well. Barbara Garcia is asking us to try to frame things in terms of recommendations now, which is a good idea. It's a challenge to turn everything that's wrong into a solution.

Ms. Shafer: I went to the Transitional Youth Committee for Prop 63. It blew me away what the kids were suggesting.

Dr. Turner: The meetings are being recorded. Our Stakeholder Committee will look at the input so far, to make sure the stakeholder input is broad enough and that the information is being captured.

## **5.0 NEW BUSINESS**

No new business.

## **6.0 PUBLIC COMMENT**

Mr. Kalman: Is this an advisory entity according to Sunshine? You are supposed to take public comment on each agenda item. You took comments from the Board and didn't allow me to ask a question.

Another comment, in the past 2-3 presentations you've had 2-3 entities regarding youth. I talked with Dr. Cabaj about the use of marijuana and what are the consequences and developmental illness. These are important questions. I think this is the meaning of the Mental Health Board. I would like when we have presentations, I would like an inventory of important issues that reach the TV or the press. Yesterday there was a disturbing program on at 10 o'clock on KQED. We have lots of things to take care of.

I saw a resolution by Supervisor Dufty and he makes a mistake in his resolution and I hope you catch it.

Mr. Pilpel: I'm aware of a resolution by Supervisor Sophie Maxwell. Perhaps you could distribute it to members of the Board. I found it a little troubling, because it was suggesting a result prior to the Task Force doing its work.

## **7.0 ADJOURNMENT**

There being no further business, the meeting was adjourned at 8:44 p.m.



## SAN FRANCISCO MENTAL HEALTH BOARD

Gavin Newsom  
Mayor

1380 Howard Street, Suite 510  
San Francisco, CA 94103  
(415) 255-3474 fax: 255-3760  
mhb@lhc.org  
www.sfgov.org/mental\_health

### MEETING OF THE MENTAL HEALTH BOARD

Wednesday, June 8, 2005  
1380 Howard, Room 537  
6:30 p.m.

DOCUMENTS DEPT.

### AGENDA

MAY 16 2005

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### CALL TO ORDER

#### Item 1.0 DIRECTORS REPORT

For discussion.

1.1 Dr. Robert Cabaj, Director, Community Behavioral Health Services  
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

1.2 Public comment relevant to Item 1.0

#### Item 2.0 PRESENTATION

For discussion.

2.1 Mitch Katz, Director of Public Health

2.2 Discussion of possible future actions related to presentation

2.3 Public comment relevant to Item 2.0

#### Item 3.0 ACTION ITEMS

For discussion and possible action.

3.1 Public comment relevant to Item 3.0

3.2 Consent Calendar:

3.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of April 13, 2005, be approved as submitted.

3.2.b PROPOSED RESOLUTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of May 11, 2005, to the following members:

3.3 Other resolutions:

3.3.a PROPOSED RESOLUTION:

3.3.b PROPOSED RESOLUTION:

**Item 4.0 REPORTS**

For discussion and possible action..

- 4.1 Report from the Executive Director of the Mental Health Board
- 4.2 Report of the Chair of the Board and the Executive Committee.
- 4.3 Other Committee Reports
- 4.4 Report by members of the Board on their activities on behalf of the Board.
- 4.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.
- 4.6 Public comment relevant to Item 4.0

**Item 5.0 PUBLIC COMMENT**

Members of the public may address the Mental Health Board on any items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board.

**ADJOURNMENT**

**DISABILITY ACCESS**

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD). Five days notice before the meeting will help to ensure the presence of an ASL interpreter or sound enhancement system. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.
2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and 14 Mission. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.
3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley which runs on the opposite side of the building from 10th Street.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

### **POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES**

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### **KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE**

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Adele Destro  
Sunshine Ordinance Task Force  
City Hall, Room 244  
1 Dr. Carlton B. Goodlett Place  
San Francisco, CA 94102-4689  
Telephone: (415)554-7724  
Fax: 4(15) 554-5163  
E-mail: [sotf@sfgov.org](mailto:sotf@sfgov.org)

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## SAN FRANCISCO MENTAL HEALTH BOARD

Gavin Newsom  
Mayor

1380 Howard Street, Suite 510  
San Francisco, CA 94103  
(415) 255-3474 fax: 255-3760  
mhb@igc.org  
www.sfgov.org/mental\_health

### MEETING OF THE MENTAL HEALTH BOARD

Wednesday, June 8, 2005  
1380 Howard, Room 537  
6:30 p.m.

DOCUMENTS DEPT.

MAY 17 2005

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### AGENDA

#### CALL TO ORDER

#### Item 1.0 PRESENTATIONS

For discussion

1.1 Dr. Robert Cabaj, Director, Community Behavioral Health Services  
A report on the activities and operations of Community Mental Health Services,  
including budget, planning, policy, and programs and services.

1.2 Mitch Katz, Director of Public Health

1.3 Discussion of possible future actions related to presentation

1.4 Public comment relevant to Item 1.0

#### Item 2.0 ACTION ITEMS

For discussion and possible action.

2.1 Public comment relevant to Item 2.0

2.2 Consent Calendar:

2.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of April 13, 2005, be approved as submitted.

2.2.b PROPOSED RESOLUTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of May 11, 2005, to the following members:

2.2.c PROPOSED RESOLUTION:

2.3 Other resolutions:

2.3.a PROPOSED RESOLUTION:

2.3.b PROPOSED RESOLUTION:

### **Item 3.0 BUSINESS**

For discussion.

- 3.1 Report from the Executive Director of the Mental Health Board  
A report including updates and announcements regarding the activities and operations of the Board.
- 3.2 Report of the Chair of the Board and the Executive Committee.
- 3.3 Other Committee Reports
- 3.4 Report by members of the Board on their activities on behalf of the Board.
- 3.5 New business - Suggestions for future agenda items or issues the Board might consider looking into.
- 3.6 Public comment relevant to Item 3.0

### **Item 4.0 PUBLIC COMMENT**

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### **ADJOURNMENT**

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## SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510  
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### MEETING NOTES

#### Mental Health Board

Wednesday, June 8, 2005  
1380 Howard Street, Room 537  
San Francisco, CA 94103  
6:30 p.m.

### DOCUMENTS DEPT.

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### PLEASE NOTE:

**There was no quorum for this meeting, therefore no votes were taken.**

**BOARD MEMBERS PRESENT:** Rebecca Turner, Ph.D. (Chair); Bob Douglas, J.D.; LaVaughn Kellum-King; James L. McGhee; Dorothy Shaffer, R.N., N.P., M.S.N.; Jagruti Shukla, M.D., M.P.H.; Kate Walker.

**BOARD MEMBERS ON LEAVE:** Benito Casados; Supervisor Bevan Dufty; Michael Medema; Toye Moses, Ph.D., M.P.H.; Lisa Williams; Idell Wilson.

**BOARD MEMBERS ABSENT:** chance martin.

### PRESENTERS:

**CANCELED.** Dr. Mitch Katz, Director of Public Health had to cancel his presentation.

**OTHERS PRESENT:** Dr. Robert Cabaj (Director Community Behavioral Health Services); Sandra Santana-Mora (Edgewood Center); Emeric Kalman; Bonnie Jean Dougherty; Tina Hasselman (Janssen Pharmaceutica); Rich Snowdon (MHB Administrator).

### CALL TO ORDER AND CONSENT CALENDAR

The meeting was called to order at 6:40 p.m. by Rebecca Turner, Chair.

### AGENDA

Dr. Katz's office called to say that he will not be able to attend our meeting tonight.

There is a change in the format of our agenda. At the last meeting it was brought to my attention that we ran out of time for members of the public to ask questions of the presenters, and people really wanted that to happen. I asked Helynn and Rich, the MHB staff, to consult with Adele Destro of the Sunshine Ordinance Task Force. We have written public comment for each agenda item right into the agenda and we will make sure there is time for it. But this means that we won't have time for members of

the public to ask questions of the presenters, which is not required under the Sunshine Ordinance.

If anyone has questions about this, please talk to Rich after the meeting or call the Mental Health Board office.

## 1.0 DIRECTORS REPORTS

### 1.1. Report from the Director of Community Behavioral Health Services

Dr. Robert Cabaj: In terms of the Mayor's budget, mental health is okay, but substance abuse services are being cut by \$3.2 million, which would annualize as a \$4.0 million reduction. This would be about half of the substance abuse outpatient budget. The Health Commission had recommended not to make that cut. Many of the contractors are concerned about this. And they are working hard with the Board of Supervisors hoping to restore those cuts.

We'll be putting the whole system out to bid, partly to be in alignment with the integration of services.

The Mental Health Association has been very helpful working on mental health planning and to get more consumers and family members involved in the planning for the Mental Health Services Act. They'll be working on a series of interventions. They're helping to host lunches on the subcommittee meeting days. They also work with consumers on how to participate in meetings, so they'll feel more comfortable attending the meetings.

With regard to Multi-Systemic Therapy, this is a licensed form of therapy and you have to buy the right to use it. But it has been extremely effective. The new Chief Probation Officer, Bill Siffermann, worked with them in Chicago. He was thrilled we were already working on this. We will be piloting it with 25 young people.

With regard to the MHSA, the subcommittees are meeting regularly. We have 11 subcommittees, and 3 or 4 meet at the same time. We're rotating the schedule a bit so people can get to more meetings. We've changed the scheduling for family members and youth and consumers. The youth definitely wanted meetings that were after school.

A week ago we were very disappointed when the Proposition 63 allocations came out from the State Department of Mental Health. The real point of the initiative is to transform the system. This initiative has been a nice incentive to stop and look at what we're doing, and to make sure our system is consumer-based, family-based, outcome-driven, and evidence-based. No matter how much money we get from the MHSA, we will use the whole amount of money we have to transform our system.

But still it's disappointing that the number was only just above \$5 million for clinical services. And that's 55% of the total. That means our county would get \$10 million total for the first year, but we had been led to believe it would be \$20-30 million.

Immediately, I started working with our City lobbyists to see what kind of influence we could have on this allocation decision. It was a formula devised by the State Department

of Mental Health. They asked for advice. But they did not factor in the homeless mentally ill. They decided there is no good homeless count, even though every county I'm aware of has done a homeless count.

They said San Francisco had claimed 40,000 homeless two years ago and now claims 6,000.

Dr. Turner: Does that come from the Mayor's office?

Mr. McGhee: Yes, they really need to say where that number comes from, especially if they're going to use that to decide on funding. Was it a legislator or DMH that made the decision?

Dr. Cabaj: That was the Department of Mental Health staff. It's going to be very hard now to change this formula. They kept it very close to their chest as they developed it. But now that it's public, if we lobby for more for San Francisco, which we will, then some other county or counties will get less if we are successful.

We feel there's prejudice against San Francisco for the homeless count. They also punished counties that have been putting extra money into mental health, beyond what the State mandated. The more you supported mental health services in the past, the less they say you need MHSA funding now.

They counted it against you if you tend to use grants and find innovative ways to bring in new money, which San Francisco does a lot. Then they used the measure of population. They are counting the potential target of need. So they are using people who are 200% or less of poverty level. But in the Bay Area that doesn't make sense. We've been arguing for 300-400% in the Bay Area. Many of our people who seek care are indigent under our definition, but not by the State's definition.

And then they used some kind of study where they estimate who is likely to come for services, and they have estimated that we have no higher level of need than other counties, even though we know San Francisco is a magnet. And we know there are counties which give people one-way bus tickets to San Francisco.

Urban areas have a higher percentage of people in need. And it would be important to factor in the cost of culturally and linguistically appropriate care. And they didn't factor in the fact that San Francisco is extremely good at outreach and finding people. As with our AB 2034 program and our Project Homeless Connect, we are finding more and more people. We are much more proactive than any other county.

Across the state the number of people with Medi-Cal who seek mental health services is 2%, but in San Francisco it's 8%. So we serve four times the number of people with Medi-Cal than the average. Partly this is because of higher need and partly because of our outreach. Since our county has what's called a higher "penetration rate," we should be getting more money. But yet they counted that against us.

I've been talking with the Mayor's staff. They are looking at what San Francisco's response should be. They're looking at working with Stephen Mayberg, and the role of



our legislators such as Leland Yee and Mark Leno. But it's not clear legally what role the legislators can play in this.

We're going to look at every option.

If you just went strictly by population, we still got less money than we should have. In fact, we got the lowest per capita rate of any county in the state.

Belinda Lyons of the MHA has been working on this too. She was outraged that the homeless were not being taken into account.

As the Mental Health Board, you can write to Department of Mental Health. Anything we can do has to be done. I don't know if it will make a difference.

If you look at the grid, it was clearly weighted to put most of the money in the southern part of the state. Southern California has been saying that we get too much money and we are "over equity." That's due to the cost of living being higher in northern California.

Mr. McGhee: Maybe the legislators in the southern part of state are doing a better job than in the northern part of the state. I've always found that legislators get involved in whatever they want to get involved in.

Dr. Cabaj: We've been working with Darrell Steinberg who is the co-author of Proposition 63, to see if he can make any difference. I've heard that Rusty Selix, the other co-author, was saying that San Francisco doesn't use its money very efficiently and that we need to prove that we can do better. He was quoting some old information about our AB 2034 project, which was slow to start up because of the bureaucracy. But once we got it running, it's done very well. We invited Stephen Mayberg to come tour the project, which he did. He spent an afternoon meeting with clients, going out and doing outreach with staff, and said he thought the program was wonderful.

Dr. Shukla: Three of the five points have to do with data. It seems like something can be done about providing the data.

Ms. Shaffer: I think we should go for talking about efficiency. Do we have a count for every program? Do we have numbers? I was just dealing with AB 3632. I was told that out of 6,000 special education students in San Francisco, 1,500 receive services under AB 3632. The State Department of Education says the total is 9,000, another group says 3,000. If we have 1,500 out of 9,000 that's a very significant number.

And I think we need to get tough on making sure that we are getting the numbers and doing the billing. It's not a question of wanting to do it, but you have to do it. We have to have solid evidence.

Dr. Turner: Did we have data in the draft plan?

Dr. Cabaj: They did not want to have any data in the draft plan. We had a discussion with one of the major decision makers who said they would look at the homeless count.

But then that was factored out. Every year when we face budget cuts, we look at the efficiency of a program and what equivalent services are costing. If one program costs twice as much as another, then we review the contractor that costs twice as much to see why that is and what can we do to change it.

Ms. Shaffer: We have to be letting people know what we are doing right.

Ms. Walker: I'm a dunderhead when it comes to finances, but is the money we're talking about tonight the planning money?

Dr. Cabaj: This is the clinical money. The planning money was disappointing, too. We got \$200,000, while Los Angeles got \$3 million. They said they did that strictly on population. Now they are giving us the allocation figure so we can tie our planning to the budget.

Ms. Walker: Is this a precedent for years to come?

Dr. Cabaj: If that formula doesn't change, yes. That's a big worry. The amount of money should go up, but we also need our percentage to go up.

Mr. Douglas: This is really bad. The staff at DMH is supposed to be isolated from politics. It's really bad that they made the allocations public this way, because the other counties won't play dead if we're going after more money. I'm going to a meeting of the California Association of Local Mental Health Boards. How do I say we need more money in front of the other counties?

Dr. Cabaj: The same is true for me when I go to the meetings of the State Mental Health Directors Association. The directors of some of the other counties look at me and say, "Well, finally we're getting what we deserve."

Mr. McGhee: Has San Francisco and the Bay Area been getting extra money?

Dr. Cabaj: Technically no. But they did factor in the cost of living in the past. The cost of living here and the cost of doing business is almost twice as high in the Bay Area as in southern California. Realignment was based on Vehicle License Fee, and when they did the formula, we got more money because of the higher cost of living. Orange County had a law suit against the entire Bay Area for years, which got thrown out.

Mr. McGhee: First, what would you like to see this Board do? Second, You're going to be providing Becky with information as we go along. Is it possible to get that information on strategy as it comes out? Third, do you think it's important that a representative from the Board be a part of the strategy meetings?

Dr. Cabaj: That may happen. We've been scrambling. The Mayor is weighing what to do. He was the first Mayor to come out in support of Proposition 63. I've also made the point that San Francisco voted 74% in favor of Proposition 63, which was the highest yes vote in the state. Maybe you could ask the Mayor's Office how they would like you to be involved. Aimee Albertson is the policy staff in the Mayor's office working on this.

Ms. Walker: How about other Bay area counties?

Dr. Cabaj: Santa Clara County is very happy. Alameda did well, but their populations are larger. The population of Alameda County is 3 million, but their entire mental health system is smaller than ours. San Mateo has close to the same population as San Francisco. Their entire mental health system, treated 11,000 consumers last year, we treated 24,000. Something's different when you have that disparity.

Ms. Shaffer: I feel like you have to do grants and research. Without those, how are we going to make a difference in mental health?

Dr. Cabaj: There will be counties that will use the money. There are still counties which would rather send their people to us. We think there will be a pool of money that won't be used, and the question is how will that be allocated? That's one other strategy we're pursuing.

Mr. McGhee: That's risky, because in today's climate with serious deficits, no one is going to want to give back money.

Dr. Cabaj: I heard one county say, "Surely we can use the money to build roads and support the jails."

Dr. Shukla: Maybe there can be some standard of accountability for the use of this money?

Dr. Cabaj: We want to change the way we contract with providers. We've been saying, "Have you treated x number of clients?" Now we want to ask how many of those clients improved. The State is saying they are going to give us guidelines on how to measure outcomes.

Mr. Douglas: The problem is that if you are a provider it's very easy to fudge this stuff.

Dr. Cabaj: There are some measures we believe can be somewhat objective. We hope the State will come up with some of those. But in any event, we want to use them.

Sai-Ling Chan-Sew, Director of Children's Services, has started building in immediate feedback, having clinicians ask at the end of each session, Did this session help?

Dr. Shukla: What are you doing regarding data?

Dr. Cabaj: We are collecting data on unmet need as part of planning for the Mental Health Services Act. Our consultants, RDA, are collecting that. And we're having a data meeting next week.

Ms. Shaffer: I think there are a lot of underserved people in multiple areas. And we need to look at the private sector because they keep sending people to the County system.

Dr. Cabaj: Another perspective is that although we see a lot of people, they still might not be getting enough services.

Dr. Shukla: Another point from a clinical perspective is that a lot of physicians in community clinics often don't code for mental health diagnoses, since they are not billing for that.

Dr. Turner: Jagruti, that sounds like that could be a very, very important consideration.

Dr. Cabaj: National figures show that 70% of mental health care is given in primary care clinics.

Dr. Shukla: Every 3rd or 4th patient may have depression. But primary care clinicians may not write that down, because it's extra work and it's not being billed for, so no one checks on that. They see it as not necessary, because no one is looking at it. But if that data were being collected, you could run the code and get that information.

I don't think the awareness is there, and the MHSA might be a trigger for motivating people to code these things.

Dr. Cabaj: We're doing a lot more work in integrating with primary care. We're probably going to set up a linking of all mental health, substance abuse, and primary care centers. You might want to get an update about that as a Board presentation. This means a primary care doctor will be able to get help with mental health clients they don't know what to do with.

The Director's written report was distributed:

**05-06 Budget Update.** The Mayor's Office has submitted its FY 2005-06 budget proposal, which will be heard before the Board of Supervisors on June 21, 3:00 PM, at City Hall Legislative Chambers. Remaining as a proposed budget cut within CBHS is the proposal to reduce substance abuse outpatient treatment services by \$3.2 million in GF, which will be accomplished through a competitive re-bid of all outpatient substance abuse treatment services. Some of the outpatient substance abuse monies will be used for expanded methadone services.

**Prop 63 San Francisco Allocation.** The California Department of Mental Health (DMH) released last week the estimates of funds to be made available for each of the counties from the Community Services and Supports (CSS) component of the Mental Health Services Act. CSS constitutes 55% of total MHSA funds, and is for local service delivery to children, youth, adults, and older adults with serious emotional disturbances and/or serious mental illnesses. The list of estimated CSS funding for each county is available at [www.dmh.ca.gov/DMHDocs/docs/letters05/05-02\\_Encl-1.pdf](http://www.dmh.ca.gov/DMHDocs/docs/letters05/05-02_Encl-1.pdf), and the distribution methodology used at [www.dmh.cahwnet.gov/DMHDocs/docs/letters05/05-02.pdf](http://www.dmh.cahwnet.gov/DMHDocs/docs/letters05/05-02.pdf). San Francisco has been given an annual CSS funding estimate of \$5,589,700—disappointingly much lower than originally expected.

San Francisco County will raise with DMH several disturbing and important issues of concern regarding this distribution of CSS funds, including: 1) why the distribution of the homeless population across the state was not considered as a factor in the distribution of CSS funds; 2) why counties, like San Francisco, which have historically invested more general funds and pursued more grant monies towards mental health services, and provided more outreach and penetration to enroll clients into services, get less CSS funds as a negative "reward" for their efforts; 3) why the distribution of CSS funds was based only on the presence of populations 200% and below of poverty, when many of the populations a little over 200% of poverty are under- or un-insured, or under-covered for their mental health treatment needs; 4) why standard estimates of prevalence (of mental illness) based on census distribution of age and ethnicity in poverty households was used, without consideration of other special factors such as the denser concentration of homelessness, health, and social problems in a geographically small city like San Francisco, which shoots prevalence rates upward; and 5) why the greater extent, seriousness, and acuity of mental health problems obtaining in large sections of the population in San Francisco (which far outweigh and outstrip the resources locally available) were not taken into account, resulting in San Francisco receiving the lowest per capita allocation of CSS funds amongst all 58 counties?

CBHS intends to pursue these serious discussions with DMH, and update all stakeholders about their response, and ultimate results.

In other developments, DMH has also released the final draft guidelines for how CSS funds can be spent by counties. The guidelines can be read at [www.dmh.cahwnet.gov/MHSA/docs/CSS%20draft-final\\_05.15.05.pdf](http://www.dmh.cahwnet.gov/MHSA/docs/CSS%20draft-final_05.15.05.pdf). These draft guidelines will go through one final stakeholder revision.

**3. San Francisco MHA To Do Prop 63 Outreach.** CBHS has engaged the services of the San Francisco Mental Health Association to assist in conducting outreach, community education, and training, to encourage the widest participation possible (especially from diverse consumers and family members) in the local Prop 63 community stakeholder planning process.

Everyone is encouraged to attend, and participate in, the planning meetings of the Behavioral Health Innovations Task Force, and its Sub-Committees which are focused on planning to identify needs, priorities, and strategies, for the use of funds from the Mental Health Services Act (MHSA) to expand and transform San Francisco's mental health services delivery system. The next MHSA Task Force meeting is on Thursday, June 16, 4:00 - 7:00 PM, at the Glide Memorial United Methodist Church, 330 Ellis St., in the Tenderloin. We hope to see a lot of you there, and there is a public comment period for you to avail of at every Task Force meeting.

**4. Memorial Fund for Bruce Franks.** Conard House has arranged a memorial fund for Bruce Franks' surviving family. Bruce lost his life in last month's shooting at Conard Community Service Center, where he worked. Please circulate this information widely to your staff, colleagues, contacts and friends. Donations can be made, and sent to, the Bruce Franks Memorial Fund, c/o Conard House, Inc., 1385 Mission St., Suite 200, SF, CA 94103. Bruce is survived by his two children - Minoria, and young son, Brian, his

life-long friend and partner, Lisa, as well as by his mother, Bernice, grandmother, Blossie, and siblings, Donald, Clarence, Sheila, Deborah and Vivian.

## 5. Other Upcoming Events:

**TRAINING ON HEALTH, BENEFITS, WORK & DISABILITY** - Over 80 City agencies are sponsoring an important one-day training opportunity for city staff who work with individuals with disabilities. The training has received high marks in other parts of California where it's already helped workers understand more about the array of benefits available to support employment for people with disabilities. Come and learn about:

MediCal & Medicare benefits for working disabled  
In-Home Supportive Services and workplace personal assistance  
Social Security's "Ticket to Work" and other Work Incentives  
Medicare's New prescription Drug Benefits, Part D

There's much more on the program for this training series. Everything you need to know about this one-day Benefits training program, which begins June 13 - 16 at the State Building, 455 Golden Gate Ave., is available at [www.db101.org](http://www.db101.org). Click on the San Francisco box for details. Cost is \$35 and payment must accompany registration form, available at [www.disabilitybenefits101.org/ca/news/news\\_1640.htm](http://www.disabilitybenefits101.org/ca/news/news_1640.htm).

**MULTI-SYSTEMIC THERAPY PROGRAM KICK-OFF & OVERVIEW** - Join the CBHS Children's System-of-Care, along with guest speaker Marshall Swenson, Vice-President, MST Services (Charleston, SC), on Tuesday, June 14, 8:30 AM - 12 Noon, at Fort Mason Conference Center, Golden Gate Room, in a discussion on how Multi-systemic Therapy will be implemented in San Francisco. MST was designed to provide communities with affordable and effective remedies for serious, violent and chronic juvenile offenders. Please RSVP via e-mail to [Jennifer.Lo@sfdph.org](mailto:Jennifer.Lo@sfdph.org) no later than June 10.

**ANNUAL TEA PARTY - OASIS OFFICE OF SELF HELP** - Come and meet the staff of OASIS, tour their facility, and celebrate the mental health community at Oasis' Annual Tea Celebration on Tuesday, June 21, 2 - 6 PM, at 1095 Market St., Suite 202. All are welcome! Please RSVP, if you can, at (415) 575-1400.

**TRAINING FOR ALCOHOL & DRUG PROGRAMS: ON FISCAL, PROVIDER BILLING, AND BIS REPORTS** - CBHS is offering a free training, on Friday, June 24, 10 AM - 12 Noon, at 101 Grove St., Room 300, for Alcohol & Drug Program Administrators, Directors, and Program Managers, on understanding and making use of Billing Information System (BIS) reports, monthly provider invoicing, and fiscal cost report analysis. Topics include: Absence of Service Report (PSP 119), Medi-Cal Caseload (DAS 510), Service Summary Report (DAS 800), CBHS Rules for Provider reimbursements, Summary Overview of Cost Report Process, monthly reconciliation, Annual Provider Settlement, and ADP 5035 Claim Cost Report Adjustments. Simply show up to attend the training - no advance registration is needed. For more info, please call Maria Barteaux at (415) 255-3536.



PARTICIPATE IN THE PLANNING MEETINGS FOR THE MENTAL HEALTH SERVICES ACT (PROPOSITION 63) - Aside from the MHSA Task Force meetings, eleven planning Sub-Committees also meet to focus on planning for specific populations and services. These sub-committee meetings are regularly held at the Bill Graham Civic Auditorium, 99 Grove St., throughout the day from 9 AM - 7 PM, on six scheduled meeting dates from April to July 2005.

The schedules of all the meetings - which are all open to the public as well as the summaries of the results of the meetings, are posted at the San Francisco Department of Public Health website at [www.sfdph.org/Prop63/default.htm](http://www.sfdph.org/Prop63/default.htm). The meeting schedules are at the following specific websites:

Behavioral Health Innovations Task Force - Schedule of Meetings at  
<http://www.sfdph.org/Prop63/TaskForceMtgSched.shtml>

MHSA Planning Sub-Committees - Schedule of Meetings at  
<http://www.sfdph.org/Prop63/SubComMtgSch04072005.pdf>

## **1.2 Public Comment relevant to Item 1.0**

Member of the Public: I have a comment about the homeless count. I just get hurt when people make negative remarks about the homeless count. We do hard work on these counts. And yes, we do have data on the number of people who are homeless on the streets. We got a count of about 14,000 in 2001 with George Smith, as Director of the Mayor's Office of Homelessness. It was the first homeless count that went all night long. That's documented. But these people who misinform other people can be proven wrong. We can stick to between 9,000 and 15,000 homeless. I've worked on this. I've done research and I know.

Ms. Hasselman: I work for a pharmaceutical company, and am going to all these mental health board meetings. The allocation issue keeps coming up. I have six counties I work with and they're all in northern California. People are not collecting the data correctly, not collecting the additional diagnoses.

Member of the Public: I have comments about planning and policies with regard to mental health. I have been a target of the police, my back has been broken, I was run over by a car, and I have organic brain damage. With regard to people's mental health in the bureaucracy and in the police force, I think it's atrocious. I have been kidnapped in an ambulance, because the police decided I was supposed to have a mental illness. I have been locked in a facility illegally. I think we have to have a whole other perspective. I have been a fly in the house of the injustice system. I've seen the courts help to make people homeless. I've seen the abuse at the hospitals.

## **Item 2.0 PRESENTATION**

Dr. Katz had to cancel at the last minute, so there was no presentation.



### **Item 3.0 ACTION ITEMS**

There was not a quorum, so no votes were taken on any action items.

#### **3.1 Public comment relevant to Item 3.0**

No public comment.

#### **3.2 Consent Calendar**

No vote was taken.

#### **3.3 Mental Health Board Bylaws**

No vote was taken.

### **4.0 MENTAL HEALTH BOARD COMMITTEES**

#### **4.1 Report from the Executive Director of the Mental Health Board**

The 14th Police Crisis Intervention Training will take place starting June 20.

#### **4.2 Report of the Chair of the Board and the Executive Committee.**

Dr. Turner: With regard to Proposition 63, the Mental Health Board will hold a hearing at the end when we have the draft plan. But also at every Task Force meeting, we're having public comment. That has turned out to be the richest part of the meetings. You've got 41 people on the Task Force, and we've been having sub committee reports. Those are good and we need to know the information in those reports, but they don't move us toward resolution. And Pat Bennett from RDA, the facilitator, is asking about policy questions and is focusing the discussions there.

The public comment has been increased from 30 minutes to an hour and they're now talking about increasing it to two hours. Idell suggested having some of the public comment earlier in the meeting, because it's hard for some people to sit through long meetings.

I would like us to talk about our role in running these public comment periods and the hearing at the end, so I can take your ideas back to the Executive Committee for further planning.

At the last Task Force meeting in Bayview/Hunters Point, the testimony was very moving. Sophie Maxwell came and talked about the violence and the PTSD and other problems in that community. She said she would be watching the Prop 63 process closely. So many people from the community came out and told their stories—professionals, family members, and consumers. It made me realize how important this part of the meeting is. It's very difficult being the facilitator. I want to discuss with you how to do this.

People have two minutes. When the bell goes off they have one more sentence, which turns into paragraphs sometimes.

We could ask at the beginning for everyone to sign up. But sometimes people come up with comments while listening to others, and we want them to have a chance to speak, too. We don't want to seem rude.

Mr. McGhee: It's very difficult to do. I think you have to set the stage on how the public hearing is going to be run. I'm a former Civil Rights Commissioner for the State of Washington, and I've held many public hearings.

Dr. Turner: We need you!

Mr. McGhee: We had hearings with 300-400 people. It's important to maintain order. You give them a time frame. You give them a warning. People can say a lot in three minutes. I've never had a problem with cutting someone off, because you may have another 50-60 people who want to speak. And people can go on and on. The people who follow behind know they are going to be cut off, and they see that and they don't want to get embarrassed. It sounds a little cold hearted, but you have to do that so everybody gets their turn.

Sometimes if there are a lot of people, I give another 30 minutes, but then at the end of that time, I say, "Thank you for coming." When you set the boundaries, people start to fall in line.

Ms. Walker: The most efficient way I've ever seen this handled is that the chair announces, "When the bell rings, you can finish your sentence." Then if the guy starts to say more, you get tough.

Ms. Kellum-King: I like the comments that were made already, but as a parent, if I come to a meeting, I'm coming for a reason, I might be hurting a lot. I suggest that the person doing the time keeping explains how things work in the beginning so individuals don't feel slighted. And hold up paper to give people the warning, so it doesn't look like the time keeper is just having a ball cutting people off.

Mr. Douglas: I used to be on the advisory board to the State Department of Rehabilitation. We had hearings all over the state. I suggest we allow them to submit additional comments in writing. If someone represents an organization of 500 people they may need more time, but they can submit a written document.

I'd like to see us do what the Mayor's Council on Disability does. They have a phone line, so people who cannot come to the meeting can call in. There are families and working people, who just can't show up. I think if we could talk to the staff at the Mayor's Council on Disability we could find out about the technology they use.

Ms. Shaffer: That one-minute or 30-second warning really helps people. The bell stops people from thinking for a moment. Are the comments being recorded?

Dr. Turner: Yes, they are being taped.

Ms. Shaffer: I like the idea of phone comments, because sometimes writing is difficult for people.

Dr. Turner: There are no other committee reports, but I wanted to talk about the Stakeholders Committee for a few minutes. At the Retreat last December we decided that the Executive Committee would take primary responsibility for the hearing, but that we would also have a Stakeholders Committee.

My memory about is it that we wanted to make sure there was the broadest possible input from people into the planning and in doing outreach. If you have any comments now, we'll pass them along to Lisa who is the Chair of that committee.

Ms. Shaffer: I'm concerned about this AB 3632 shift in services from CBHS to SFUSD. That's 1,500 students, their families, and their healthcare providers. I don't know if any of these folks are being informed. I haven't been able to get anyone to say who's responsible for this. I think all stakeholders should get something in the mail.

Dr. Shukla: I think tapping into clinics is always a great idea, finding a contact person, and letting them know what you want to share or find out. Then let them spread that through their organizations.

Dr. Turner: We need to find out what the City is doing in terms of outreach.

Ms. Shaffer: With regard to the Youth Guidance Center, I'm not sure if half those parents know their kids are getting mental health services. We should bring that up to the new Chief of Probation.

Dr. Turner: There are wonderful and powerful things people can do to galvanize and organize. At the last Task Force meeting, someone from the Public Defenders Office testified, along with the arresting officer, and a guy with schizophrenia who had been in prison. It was very powerful testimony.

#### **4.3 Other committee Reports**

No reports.

#### **4.4 Report by members on their activities or on behalf of the Board.**

Ms. Kellum-King: I would like to report that the NAMI Walk was quite successful. Over \$250,000 was raised. And money is still coming in.

#### **4.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.**

Ms. Shaffer: I sit on the Community Advisory Committee for Special Education. I got there as a family member but also as an MHB member. I found out that the AB 3632 special education program is possibly going to be eliminated. The school district spends about \$18 million after they get MediCal reimbursement. There are 6,000 special education students out of 60,000 total students in the SFUSD. Of those 6,000, there are 1,500 who get some level of mental health services, from counseling to residential services.

The school district is not a mental health provider, so how are they going to take over these services? It's a mandated service but there is no funding for it.

I'm concerned about the fact that there are already lawsuits for the lack of providing services. And how much will that go up if this is turned over to the school district?

#### **Public comment relevant to Item 4.0**

My name is Bonnie Jean Dougherty. I'm seeking a consumer seat on the Board. I would like to apologize to the Board members and the Chair. In no way did I mean that people were not doing their job in that they did not know there was a set number of people who were homeless. I was very nervous when I was speaking. If I offended anyone, I apologize. I applaud everyone here. I've always been an advocate for many social issues all my life.

#### **5.0 PUBLIC COMMENT**

Sandra Santana-Mora: I work at the Edgewood Center. We had a team of 50 employees who went on the NAMI Walk. It was amazing to be with the mental health community that day. The event was a great success.

The Edgewood Center has been re-accredited by the Council on Accreditation. This is a very prestigious award. We're very proud of it. I wanted to share that with you so that you can know that the services provided by the City are in good hands.

I've been tracking the AB 3632 issue. The Governor has made the decision to transfer the administration of AB 3632 from county mental health to the school districts. There is some additional federal funding they can get if they make this transfer.

I think it will be okay, because school districts have no way of providing those services, so they will probably contract with CBHS, or they will do a direct bidding to service providers. In terms of actual service delivery, the general perception is that there is not going to be a problem, though this is something to keep watching, because it is a very critical issue.

Tom McDonough: I'm with San Franciscans for Laguna Honda. The building was to be rebuilt with 1200 beds. That doesn't seem to be the case now. The situation is absolutely deplorable. They must think the voters are awfully stupid. It breaks our trust in elected officials. If the officials feel they can mess with the money like this, then they will lose the trust of the voters. It's a deplorable situation. There are indications, they may end up with only 300-400 beds there. The population is aging in America. Therefore a responsible official would say we need more beds. That's not what they are thinking. It's all about the money. And that's wrong. Our elected system should primarily be about people. Once the system forgets that, it's making a terrible mistake.

Member of the Public: With regard to Proposition 63, I've recovered from brain damage I don't think anyone has recovered like I've recovered. I can help kids through guided meditation instead of putting them on Ritalin. I've worked a lot with alternative medicine over the years. I've helped cure people of things like postpartum depression. When are we going to have results-oriented competition? When is there going to be accountability for people who are violating it. How can people kidnap someone like me? I was kidnapped by the police. My back has been broken several times. I've talked

to Sophie Maxwell. I've talked to people from the left who say we'll go in and watch. Let us into the horrible and sadistic environments. This is not mental health. This is not good for the community. We have to look at the spiritual aspect. Where are the successful people's guidelines? Can we implement the things that have worked in various countries? Like Buddhism.

Mr. Kalman: I would like to follow up on the previous speaker. We used to have a representative, the head of the Police Department to give a report on the 5150's. So why not use the same approach? Let's get the police chief here to give a report.

Also, how are the police handling the homeless people when they pick them up? Are they picked up on 5150's or other police codes? What about when the Fire Department comes out, when someone has passed out on the street? And why sometimes when the medical crew comes, do they do a quick diagnosis and then leave and let the person stay there? They determine he doesn't need any help. Let's get the Police and Fire Departments here.

Also related to Proposition 63, why is Recreation and Parks Department not at the table? They have to have recreation programs for people who are disabled.

Hazel Salvana: This is my first MHB meeting. Thank you very much for inviting me. I have a comment about the police and people with mental illness. I think one of the best ways for the police or anyone in law enforcement to really understand about mental health people is to have inservices and education. The police deal with a population that has mental illness, so they should understand what it's like having a mental illness. Everyone from law enforcement should have continuing education on this.

#### **ADJOURNMENT**

There being no further business, the meeting was adjourned at 8:28 p.m.





# SAN FRANCISCO MENTAL HEALTH BOARD

Gavin Newsom  
Mayor

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www.sfgov.org/mental\_health

## MEETING OF THE MENTAL HEALTH BOARD

Wednesday, July 13, 2005  
1380 Howard, Room 537  
6:30 p.m.

### AGENDA

DOCUMENTS DEPT.

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### CALL TO ORDER

### ROLL CALL

### AGENDA CHANGES

#### Item 1.0 DIRECTORS REPORT

For discussion.

1.1 Dr. Robert Cabaj, Director, Community Behavioral Health Services  
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

1.2 Public comment relevant to Item 1.0

#### Item 2.0 PRESENTATION

For discussion.

2.1 Mitch Katz, Director of Public Health

2.2 Discussion of possible future actions related to presentations

2.3 Public comment relevant to Item 2.0

#### Item 3.0 ACTION ITEMS

For discussion and possible action.

3.1 Public comment relevant to Item 3.0

3.2 Consent Calendar:

3.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of May 11, 2005, be approved as submitted.



3.2.b PROPOSED RESOLUTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of June 8, 2005, to the following members: Benito Casados, Michael Medema, and Toye Moses, Idell Wilson, Lisa Williams

3.2.c PROPOSED RESOLUTION: To commend Kalifa Coulibaly, Owen Spaulding, and Gregg Wozniak for their courageous and life-saving actions at the Conard House office on May 9th. (Attachment A)

3.2.d PROPOSED RESOLUTION: To commend Officer Kevin Gotchet of the San Francisco Police Department for his actions to prevent additional tragedy on May 9th. (Attachment A)

3.2.e PROPOSED RESOLUTION: Be it resolved that the meeting notes of the Mental Health Board meeting of June 8, 2005, be approved as submitted.

3.2.f PROPOSED RESOLUTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of July 13, 2005, to the following members: Idell Wilson

3.2.g PROPOSED RESOLUTION: Be it resolved that the Mental Health Board honors Linda Wang for her 34 years of service to the City. (Attachment B)

3.2.h PROPOSED RESOLUTION: To state the Mental Health Board's concerns about the reduction of substance abuse funding. (Attachment C)

3.2.i PROPOSED RESOLUTION: To endorse the letter written by Belinda Lyons of the Mental Health Association stressing why the allocation of funds to San Francisco from Proposition 63 money should be increased. (Attachment D)

### 3.3 Other resolutions:

3.3.a PROPOSED RESOLUTION: Be it resolved that the Mental Health Board amend its bylaws to revise its attendance policy for Board members, to add duties mandated by the Mental Health Services Act (Proposition 63), and to make additional minor changes. (Attachment E)

3.3.b PROPOSED RESOLUTION: In opposition to Governor Schwarzenegger's special election. (Attachment F)

## Item 4.0 REPORTS

For discussion and possible action..

4.1 Report from the Executive Director of the Mental Health Board

4.2 Report of the Chair of the Board and the Executive Committee, including a report on the status of Proposition 63 planning and hearings to be held by the Mental Health Board.

### 4.3 Other Committee Reports

### 4.4 Report by members of the Board on their activities on behalf of the Board.

### 4.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

### 4.6 Public comment relevant to Item 4.0

## Item 5.0 PUBLIC COMMENT

Members of the public may address the Mental Health Board on any items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board.

## ADJOURNMENT

### DISABILITY ACCESS

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD). Five days notice before the meeting will help to ensure the presence of an ASL interpreter or sound enhancement system. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.
2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and 14 Mission. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.
3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley which runs on the opposite side of the building from 10th Street.
4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

### POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES

The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

### KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Adele Destro  
Sunshine Ordinance Task Force  
City Hall, Room 244  
1 Dr. Carlton B. Goodlett Place  
San Francisco, CA 94102-4689  
Telephone: (415)554-7724  
Fax: 4(15) 554-5163  
E-mail: [sotf@sfgov.org](mailto:sotf@sfgov.org)

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from Ms. Hall, or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: [www.sfgov.org/sunshine.htm](http://www.sfgov.org/sunshine.htm)

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: [www.sfgov.org/mental\\_health](http://www.sfgov.org/mental_health). You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

### **Lobbyist Registration and Reporting Requirements**

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site [www.sfgov.org/ethics](http://www.sfgov.org/ethics).

**MENTAL HEALTH BOARD**  
**ATTACHMENT A**  
July 13, 2005

**Agenda Item 3.0**

**3.2.c PROPOSED RESOLUTION: To Commend Kalifa Coulibaly, Owen Spaulding, and Gregg Wozniak and present them with certificates as follows:**

*The Mental Health Board of San Francisco commends*

**Kalifa Coulibaly**

*On May 9, 2005, at the time of a fatal shooting  
at the office of Conard House Community Services,  
you took immediate and effective action  
at great personal risk  
to control and disarm a dangerous and determined assailant,  
thereby saving an unknown number of lives.  
For your courageous action  
we give you our deepest gratitude.*

*The Mental Health Board of San Francisco commends*

**Owen Spaulding**

*On May 9, 2005, at the time of a fatal shooting  
at the office of Conard House Community Services,  
you took immediate and effective action  
at great personal risk  
to control and disarm a dangerous and determined assailant,  
thereby saving an unknown number of lives.  
For your courageous action  
we give you our deepest gratitude.*

*The Mental Health Board of San Francisco commends*

**Gregg Wozniak**

*On May 9, 2005, at the time of a fatal shooting  
at the office of Conard House Community Services,  
you took immediate and effective action  
at great personal risk  
to control and disarm a dangerous and determined assailant,  
thereby saving an unknown number of lives.  
For your courageous action  
we give you our deepest gratitude.*

3.2.d PROPOSED RESOLUTION: To commend Officer Kevin Gotchet and present him with a certificate as follows:

The Mental Health Board of San Francisco commends

**Officer Kevin Gotchet**

*On May 9, 2005, at the time of a fatal shooting  
at the office of Conard House Community Services,  
you responded immediately,  
assessed a complex situation accurately,  
and prevented any further tragedy from taking place..  
For this we give you our deepest gratitude.*

MENTAL HEALTH BOARD  
ATTACHMENT B  
July 13, 2005

PROPOSED RESOLUTION (MHB-2005-xx): Be it resolved that the Mental Health Board honors Linda Wang on the occasion of her retirement and presents her with a certificate of appreciation as follows:

*The Mental Health Board  
honors*

***Linda Wang***

*For over 34 years of dedicated service to San Francisco  
as a clinician and administrator  
in the many different incarnations of the mental health system.*

*For your outstanding leadership  
as Director of Adult and Older Adult Services  
for Community Behavioral Health Services.*

*For your integrity and for your kindness  
in dealing with clients, family members, staff, and the public.*

*For championing innovative programs.  
For your calm demeanor in the face of serial crises.  
For being so accessible to the Mental Health Board  
and for being a steadfast supporter of our work.*

*We wish you the best as you leave behind  
piles of paperwork and relentless budget battles,  
and instead start taking classes for fun, travelling to new places,  
and spending lots and lots of time  
playing with your granddaughter.*





MENTAL HEALTH BOARD  
ATTACHMENT C  
July 13, 2005

**PROPOSED RESOLUTION (MHB-2005-xx) In opposition to severe cuts to substance abuse services**

WHEREAS, the Mayor has proposed a severe cut of over three million dollars to the funding for substance abuse services for fiscal year 05/06, and whereas these cuts would lead to a 50% reduction of outpatient treatment, and

WHEREAS, San Francisco is in desperate need of increasing services for people with substance abuse problems, and

WHEREAS, a significant number of mental health clients have a dual diagnosis and also suffer from problems with substance abuse, and

WHEREAS, the homeless population of San Francisco is in particular need of receiving substance abuse services, now, therefore

BE IT RESOLVED, that the Mental Health Board of San Francisco thanks the Health Commission for voting against cuts to substance abuse services, and thanks the Budget Committee of the Board of Supervisors for voting to restore funding to substance abuse services, and,

BE IT FURTHER RESOLVED, that the Mental Health Board of San Francisco urges the Mayor to support the restoration of funding for substance abuse services and to work with the Board of Supervisors to make that a reality.



**MENTAL HEALTH BOARD**  
**ATTACHMENT D**  
July 13, 2005

**PROPOSED RESOLUTION (MHB-2005-xx):** In opposition to the State allocation plan for the Mental Health Services Act

WHEREAS, the Department of Mental Health of the State of California has approved an allocation plan for the Mental Health Services Act which gives the County of San Francisco the lowest per capita funding of any county in the state, and

WHEREAS, critical mental health needs named in the Mental Health Services Act were not taken into account in the allocation plan, and

WHEREAS, the allocation of the funding should be determined based solely on need and not on politics, now, therefore

BE IT RESOLVED, that the Mental Health Board of San Francisco endorses the allocation letter written by Belinda Lyons, Executive Director of the Mental Health Association, dated June 15, 2005, and adopts this letter as the official policy of the Mental Health Board, and

BE IT FURTHER RESOLVED, that the Mental Health Board commends Mayor Gavin Newsom, State Senators Carole Migden and Jackie Speier, Assembly Members Mark Leno and Leland Yee, the Board of Supervisors, Mitch Katz, Director of Public Health, and Barbara Garcia, Co-chair of the Behavioral Health Innovations Task Force, Robert Cabaj, Director of Behavioral Health, Belinda Lyons of the Mental Health Association, and the San Francisco Proposition 63 Campaign Committee for doing everything in their power to correct the allocation formula in order to bring it in line with the intent of the initiative and to bring San Francisco's share of the funding in line with the reality of the need for mental health services in our city.



June 15, 2005

Steven Mayberg, Ph.D.  
California Department of Mental Health  
1600 9th Street, Room 151  
Sacramento, CA 95814

Re: Department of Mental Health Release of Mental Health Services Act Planning Estimates.

Dear Dr. Mayberg,

Under the Department of Mental Health estimates on the probable allocation from the Mental Health Services Act Community Services and Supports funding released on June 1, San Francisco is formulated to receive \$5,332,900.

I am writing because we are very concerned about this proposed allocation and believe that the formula used as the basis for allocating funds is flawed. The Mental Health Services Act was crafted in the spirit of bringing resources to where there is need. The allocation formula needs to be re-examined and revised prior to any funds being distributed as the proposed allocation does not accurately reflect the need for mental health services in the state.

As you know, The Mental Health Association of San Francisco is a non-profit citizen's organization dedicated to improving the mental health of residents in the diverse communities of San Francisco through advocacy, education, research and service. We are the local affiliate of the National Mental Health Association and the Mental Health Association in California.

San Francisco voters supported Proposition 63 at nearly 74%, over 20 points above the statewide average. This not only reflects the commitment of the San Francisco voters to mental health issues in general, but it specifically acknowledges the great need for mental health services in this county.

Problems with the current formula include:

Weight given towards raw population. The weight given to population (50%) is quite high. Such emphasis clearly tips the scale in favor of the southern part of the state. After giving it thorough consideration, we believe that this factor should be weighted at no more than 30% of the base. Further, the accuracy of the census numbers should be examined and adjusted to reflect estimates of people who are homeless. The homeless population is un-counted in the census. Of this population, 39% report some form of mental health problem, 20-25% meet the criteria to be determined Seriously Mentally Ill, and 66% report some form of either substance abuse and/or mental health problems. This is a major issue for San Francisco and should be given due consideration in the allocation formula.

Adjustment based on resources. Counties are adjusted DOWN if they have used general fund and/or are innovative in seeking and applying for State and Federal grants to address mental health needs. In other words, counties like San Francisco, which recognized the need to address mental health problems, are "punished" for having done the right thing whereas counties that have not, are "rewarded." There is a reason why San Francisco has historically allocated more funds to mental health: the need is great.

Self-Sufficiency. The Self Sufficiency score used in the "Adjustments" area is helpful to address some of the cost of living imbalance in the Bay Area. However, it does not cover the high cost of doing business in San Francisco and the added cost of providing culturally, ethnically, and linguistically sensitive services that are the majority of services provided in San Francisco. It costs more to train and hire staff and to provide translation as needed. The formula should take into account the higher cost of providing services in highly dense, ethnically and culturally diverse areas.

Defining the population most likely to apply for services. The poverty definition is defined as households with incomes below 200% of the federal poverty level. This level needs to be higher--300% or even 400%--to capture the population in the Bay Area likely to be uninsured or underinsured because of the high cost of living, and in order to capture a more realistic definition of "poverty" or "indigent needs" in San Francisco and the Bay Area.

Population most likely to access services. A single study is mentioned to describe the prevalence of mental illness in areas accounting for age and ethnicity in poverty households. Such a study does not address the challenges specific to San Francisco; our county does not follow usual prevalence rates of mental illness because it always welcomes, and provides for, a large number of clients from other counties who need services. Further, San Francisco serves as a magnet for people who elect on their own to come to San Francisco. This contributes to homelessness and other social problems. The prevalence study would have 15,536 SMI and SED individuals in San Francisco below 200% poverty, when in reality our public mental health system serves over 22,000 unduplicated clients and many in need are turned away or inadequately served.

Two facts about this county: 1) San Francisco has a much higher than average prevalence of mental illness, and 2) San Francisco has a much higher than average cost of delivery of services. These two factors suggest that on a per capita basis of the population, San Francisco should receive a higher than average per capita allocation. However, according to the proposed formula, San Francisco's allocation was the lowest per capita allocation of CSS funds among all 58 counties. This clashes with the fact that San Francisco has a greater extent, seriousness, and acuity of mental health problems in large sectors of the population, which outstrip the resources locally available despite these being proportionally higher than other counties. While no one factor should determine the exact funding levels, the absurdity of the tiny per capita allocation for San Francisco illustrates the gross inaccuracy of the proposed formula at truly and fairly addressing mental health needs in the state. We urge you to reconsider.

The Mental Health Services Act requires that funds are allocated based on need and ability to provide services and is specifically designed to encourage a rehabilitation

focus throughout county mental health programs. San Francisco has led the way in developing recovery-based alternatives to institutional settings including supportive housing. In fact, these services have been an integral part of the county system for over 25 years. The formula revision should also consider the current array of services in each county and give additional weight to those counties that have already shown a capability and willingness to develop programs that are consistent with the intent of the MHSA. Instead, as proposed, counties that have a long history of utilizing institutional placements would receive disproportionately large preliminary allocations.

Last, in addition to revising the current proposed CSS allocation to appropriately address the factors discussed above, we also urge you NOT to apply the current flawed formula to the remaining 45% of MHSA funds to be allocated. Moreover, to the extent that counties may apply for discretionary funding, it should be distributed to address homelessness and other factors mentioned here.

Sincerely,

Belinda Lyons  
Executive Director

Cc: Barbara Garcia  
Assembly member Mark Leno  
Senator Carol Migden  
Mayor Gavin Newsom  
S.F. Proposition 63 Campaign Committee  
Darrell Steinberg  
Rusty Selix  
Senator Jackie Speier  
Assembly member Leland Yee





**MENTAL HEALTH BOARD**  
**ATTACHMENT E**  
July 13, 2005

**PROPOSED RESOLUTION (MHB-2005-xx):** Be it resolved that the Mental Health Board amends its bylaws as recommended by the Executive Committee in order to revise its attendance policy, to include the new state mandate regarding the Mental Health Services Act (Proposition 63), and to make additional minor changes.



MENTAL HEALTH BOARD  
ATTACHMENT F  
July 13, 2005

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**PROPOSED RESOLUTION (MHB-2005-xx) In opposition to Governor Schwarzenegger's special election**

WHEREAS, Governor Arnold Schwarzenegger has used special executive powers to declare a special election for California on November 8, 2005, and

WHEREAS, the items on the ballot for that special election will be five or more of the Governor's own initiatives, and

WHEREAS, this special election is seen by many Californians as a means for the Governor to do extensive fundraising and to further his own political ambitions, and

WHEREAS, the initiative process has never been used in this way before, and many Californians believe it was never intended to be used in this way, and

WHEREAS, two-thirds of Californians are opposed to this special election, and

WHEREAS, the cost of this special election to California counties is estimated to be \$45 million dollars at a time of severe budget deficits, and

WHEREAS, the cost of this special election uses state funding needlessly when San Francisco, like other counties, is in desperate need of funds for housing the homeless, residential treatment facilities for the mentally-ill, outpatient programs for people struggling with substance abuse and alcohol abuse, outreach teams, increased mobile crisis services, a 24/7 drop-in center for people in crisis, and for many other urgent needs, and

WHEREAS, a regular election is scheduled for only seven months later in June 2006, and

WHEREAS, the issues set forth in the Governor's initiatives which will be on the ballot are complex and complicated issues and cannot adequately or realistically be addressed with a yes or no vote, and

WHEREAS, the initiatives on the ballot for the special election will have a profound impact on the future of California's political process and education system, and

WHEREAS, voter turnout for special elections is significantly lower than for regular elections, and

WHEREAS, many Californians view that the Governor is using the initiative process and his personal popularity to bypass the kind of serious democratic debate and detailed public input that his initiatives actually require, now, therefore

BE IT RESOLVED, that the Mental Health Board of San Francisco urges the Mayor and the Board of Supervisors to take a public position on behalf of the City and County of San Francisco in opposition to the special election being called by Governor Schwarzenegger for November 8, 2005, and

BE IT FURTHER RESOLVED, that the Mental Health Board of San Francisco urges the Mayor and the Board of Supervisors and other city leaders to speak out in opposition to the passage of the Governor's initiatives, not only on the basis of the content of those initiatives but as a matter of principal and as a matter of defending our democracy.



## SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510  
San Francisco, CA 94103  
(415) 255-3474 fax: 255-3760  
mhb@igc.org  
www.sfgov.org/mental\_health

### UNADOPTED MINUTES

#### Mental Health Board

Wednesday, July 13, 2005  
1380 Howard Street, Room 537  
San Francisco, CA 94103  
6:30 p.m.

DOCUMENTS DEPT

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**BOARD MEMBERS PRESENT:** Rebecca Turner, Ph.D. (Chair); Benito Casados; Bob Douglas, J.D.; La Vaughn Kellum-King; James L. McGhee; Michael Medema; Toyé Moses, Ph.D., M.P.H.; Dorothy Shaffer, R.N., N.P., M.S.N.; Jagruti Shukla, M.D., M.P.H.; Kate Walker; Lisa Williams.

**BOARD MEMBERS ON LEAVE:** Supervisor Bevan Dufty; Idell Wilson

**BOARD MEMBERS ABSENT:** chance martin.

#### PRESENTERS:

Dr. Mitch Katz, Director, Department of Public Health

**OTHERS PRESENT:** Dr. Robert Cabaj (Director Community Behavioral Health Services); Mark Wang; Miriam Martinez (UCSF/SFGH); Uy Hoang (UCSF/Yale); Dale Milfay (NAMI); Sandra Santana-Mora (Edgewood Center); Emeric Kalman; Juan De Anda (Consumer); Helynn Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

#### CALL TO ORDER

The meeting was called to order at 6:35 p.m. by Rebecca Turner, Chair.

#### ROLL CALL

#### AGENDA CHANGES

#### 1.0 DIRECTORS REPORT

##### 1.1. Report from the Director of Community Behavioral Health Services

Dr. Robert Cabaj: Linda Wang, Director of Adult Services, has retired after 35 years. Edwin Batongbacal has taken on her position and then we'll be recruiting to replace him as my deputy.

With regard to the budget, after a long process we got almost everything restored by the Board of Supervisors. This was largely due to great advocacy by the community. The substance abuse providers did an especially good job of advocacy. The Board of Supervisors also added back the mid-year cuts to fund the single standard of care again. Cindy Gori was very helpful in coordinating a major effort with the Board of Supervisors. They not only restored the money, but then yesterday they adopted an administrative code change that means the single standard of care is now required. I believe it was a unanimous vote as well.

Dr. Katz and I are meeting tomorrow with Dr. Stephen Mayberg, Director of the State Department of Mental Health, about the Proposition 63 allocation issue. Our belief is we probably won't make much change in the formula. But perhaps we can change the formula for next year. And there is a set aside amount of money. We're looking at that, perhaps tying that to homeless clients in San Francisco. Senator Carole Migden is helping us with this.

In the allocation process, San Francisco ended up with the least amount per capita of any county in the state.

The oversight commission for Proposition 63 has been appointed. Darrell Steinberg is the Chair. He is a co-author of the proposition and is a great advocate. He has put the allocation formula on the agenda for next week. Lynford Gayle is co-chair of the oversight committee. He used to work for us. We think he will be very helpful.

We're continuing our full integration of substance abuse and mental health. We're working with ZiaLogic and our change agent group is quite active. They are meeting regularly. We're working on the next phase of how primary care will work with us more closely.

The State Department of Mental Health is planning to have the final guidelines out for Proposition 63 planning by August 1. We are hoping to release our final draft by August 23rd.

The Director's written report was distributed:

**Linda Retires.** After 35 years of outstanding service with the Department of Public Health, Community Behavioral Health Services, Linda Wang, LCSW, Director of Adult/Older Adult Systems-of-Care, retired last June 30.

We miss Linda very much, but we're also very happy for her in her retirement. Please join us in a celebration of Linda's longstanding dedication and leadership accomplishments on Thursday, August 18, 2005, 6 - 9 PM, at the Yank Sing Restaurant, 101 Spears Street (at Mission St.), SF.

Buffet of dim sum & other dishes will be served at the reception. To participate in the celebration, please send check of \$45 payable to Sai-Ling Chan-Sew (due by Thursday, August 11, 2005) to Antonio Trink, c/o Community Behavioral Health Services, 1380 Howard St., 5th Floor, San Francisco, CA 94103.



**05-06 Budget Update.** Good news. The SF Board of Supervisors voted to restore \$3.2 million in slated cuts in substance abuse outpatient treatment services for 05-06, as well to amend the Administrative Code to institute a policy of single standard of care for the medically-indigent.

**Prop 63 San Francisco Allocation.** Mayor Gavin Newsom, in a press conference last June 30, pledged to fight for more Mental Health Services Act (MHSA) dollars for San Francisco, in the wake of the release of county funding estimates by California Department of Mental Health that showed San Francisco receiving the lowest per capita allocation of MHSA Community Services & Support funds among all of the 58 counties. SF is estimated to get only \$5.5 million in CSS funds for all of the mental health service and support delivery to children, youth, adults, and older adults.

The state formula for calculating each county's allocation is ultimately based on household census population, instead of on actual number of citizens in need of the mental health services, Mayor Newsom said. Because of San Francisco's smaller size, and its relatively huge numbers of individuals in need of mental health services who are not counted in the census (such as the homeless, the institutionalized, and the undocumented), the county will receive less share of CSS money than what is proportional to the county's need.

Mayor Newsom has the City Attorney's Office looking into a possible lawsuit against the state. In addition, the City's health officials and state lobbyists are trying to find a way to get more MHSA CSS funding for San Francisco. State Senator Carole Migden, D-San Francisco, has vowed to increase San Francisco's allocation by as much as \$10 million. Officials from SF Department of Public Health will meet very soon with state Department of Mental Health officials to discuss San Francisco's under-funding in CSS monies.

**4. Behavioral Health Integration Enters FY 2005-06.** Ken Minkoff and Chris Cline conducted their quarterly two-day visit with CBHS last June 23-24, and met with the CBHS Change Agents, and with the CBHS Executive Team, Integration Advisory Committee, and Integration Implementation Workgroup to begin work on what will be the System Action Plan for CBHS Behavioral Health Integration for the new fiscal year 2005-06.

After a year of working with ZiaLogic on behavioral health integration, CBHS has put the following change processes into place:

- an internal CBHS integration implementation team
- an integration advisory committee
- a group of inspiring and dedicated change agents
- an effective communication tool, the "Tools of the Trade" newsletter
- a website, [www.dph.sf.ca.us/CBHS/default.htm](http://www.dph.sf.ca.us/CBHS/default.htm)
- the full roll-out of the COMPASS and COFIT toolkits
- a number of CBHS programs embarking on integration quality improvement initiatives
- a great consulting team, Ken, Chris and David Mee-Lee

a deeply-held model of participative implementation  
a vision for the system (Comprehensive, Continuous, Integrated System-of-Care)  
trainings of hundreds of staff and consumers throughout CBHS on the model and  
vision for integration, and on integrated treatment for co-occurring disorders

Planning will take place in the next month on new, as well as continuing, integration initiatives and projects that will be undertaken in CBHS for 05-06. Stay tuned and involved.

## **1.2 Public Comment relevant to Item 1.0**

No public comment.

### **Item 2.0 PRESENTATION**

Dr. Turner: We're pleased to have Dr. Katz here tonight. He'll begin with an opening statement of five minutes. Then we'll have a series of questions from the Executive Committee, asked by Michael Medema. Finally I'll call on other Board members for questions.

Dr. Mitchell H. Katz earned a B.A. in Psychology from Yale University in 1981 and was awarded an M.D. degree at Harvard Medical School in 1986. His residency in Primary Care Internal Medicine at the University of California, San Francisco (UCSF) from 1986-89 was followed by an appointment as Clinical Scholar, Robert Wood Johnson Foundation at the UCSF from 1989-91.

Dr. Katz's public health career spans 14 years in a variety of positions with increasing scope and responsibilities. Prior to his appointment as Director of Health, he served as Director of the Community Health & Safety unit of the Department of Public Health. He has served as Interim Medical Director for Emergency Medical Services, Director of Epidemiology, Disease Control & AIDS, Director of the AIDS Office and Chief of the Research Branch of the AIDS Office.

He has published extensively in a variety of professional medical journals and books and is author of a celebrated text book required by many training schools and universities, "Multivariable Statistics for Clinical Researchers," published by the Cambridge University Press. He currently holds a teaching position as Assistant Clinical Professor of Medicine and Epidemiology, UCSF School of Medicine and maintains a clinical AIDS practice at San Francisco General Hospital with the Community Health Network.

He and his son, Max, reside in San Francisco.

Dr. Katz: Many of the clients I work with at San Francisco General Hospital are dealing with mental illness. I have two primary family members with mental illness, and so it's an issue close to my heart and one I try to stay knowledgeable about.

With regard to Proposition 63, there was a lot of disappointment about the state allocation. It's not a lot of money. And yet, it is a lot of money. To bring that much money into our system and spend it well is not an easy challenge. And we want to take the challenge of spending the rest of our funding better. We can always do better. We

can always be more culturally competent. I hope we always try to do better whether our budget is high or low.

Mr. Medema: The first question is about the budget process and how you can include this Board in the process. As it is now, mostly we hear about the budget after the fact, after it's been presented to the Health Commission. Would you be willing to come to this Board meeting once a year, and meet with our Executive Committee once a year? What other ways are there for us to be involved in the budget process?

Dr. Katz: I'd be delighted to come to the Board and to meet with the Executive Committee. Our Department is huge. So a lot of the work gets done at the level of our deputy directors and people like Bob Cabaj.

The budget is almost a year around affair. It's still not over yet for this year. Amendments will be made to it this week and it will be passed in two weeks. I began working with my staff on this budget last October.

If the MHB wants to be more involved, which I would welcome, I would say the central question is what would be your recommendations on how mental health money gets spent, whether the figure is plus, minus, or the same.

That last part you never know. We were minus until a week ago. Don't wait to hear the budget instructions. Make clear what is the Board's wish for the mental health budget, whether it's bigger, smaller, or the same. It's a pretty hefty budget. You won't know what the final outcome is until the very end. So you won't have impact if you wait until then.

For example, the AIDS Department has decided they are moving to a Center of Excellence model no matter how much money they receive. They made a plan to spend the first \$8 million in their budget on this, and planned where it would come from. They are putting primary care in the center and then wrapping other services around that.

Mr. Medema: Who would those recommendations be made to?

Dr. Katz: What makes a recommendation stick in this city is that it is a consensus. If you come up with a recommendation, it would be important that there is a consensus with administration and providers. You could make your own recommendations stronger that way.

I get your minutes and I read your minutes, so I know what you're talking about at your meetings, and I talk with Bob as Director of CBHS.

Mr. Medema: Barbara Garcia is putting together a list of budget-related meetings and we'll follow up on that.

The most recent budget reductions made cut backs in the Single Standard of Care, which means that uninsured and homeless people are not getting services they need. What is DPH doing to keep these former clients from going into crisis and returning to

the hospital or other institution? How could we reduce institutional funding so we can provide the services these clients need to keep them in the community?

Dr. Katz: This first question is happily somewhat moot, given the actions of the Board of Supervisors.

But that second question is a very deep and important question. As a department we do not want to be institutionalizing people unless that is the only safe option, whether it is short term or long term. I believe there is room to decrease institutionalization in this community.

To some extent you've already succeeded. Compared to ten years ago, you've already made tremendous progress. But what is the process for the next phase? I think some of it centers on dual diagnosis, including people who have a primary mental health diagnosis, but are doing fine in the absence of drugs. Or people with no mental health diagnosis, but when using drugs they have a mental health-like illness. And the use of the speed drugs is causing much unnecessary hospitalization.

Heroin is a very serious drug, but people who use it don't exhibit mental health-like symptoms as is the case with speed. So getting better substance abuse treatment will help. And figuring out how to do Board and Care placements in a more affordable way.

Mr. Medema: What *objective* evidence do we have that the Housing First policy works? Which clients need residential treatment, and which clients need supportive housing?

Dr. Katz: We track those people who enter our Urban Health Programs, which are directed by Marc Trotz. We look at what happens to people before they go in and what happens after. We have been able to show a significant decrease in hospitalization, incarcerations and use of emergency care for people who are housed. Trying to arrange clinical routines for someone who is homeless just doesn't work. We have a lot of experience with this.

We can house someone with supportive services for \$1,000 per month. The cost of single hospital day is \$1,000. So if you can get housing for people, you're going to save money. I also believe people have a right to be housed.

The other question you're asking about, I may not be the best person to answer. You're asking about the level of service. The minimum we do, is to provide housing and a door person for security. For other people to make it successfully, they might need intensive case management and on-site psychiatric or medical care. I think it's important that we recognize that people need a spectrum of services. We try to make each building a slightly different service mix.

Mr. Medema: With sufficient funding, would you support Mobile Crisis operating 24/7? Dr. Katz: Yes.

Mr. Medema: Would you support a 24/7 Drop-in Center? Dr. Katz: Yes.

Mr. Medema: We've received information about Central Access that concerns us:

- a. When the State audit team called Access three times as part of the audit, none of those calls were answered by Access.
- b. We've been told that calls transferred from the front desk at 1380 Howard to Access frequently bounce back.
- c. When Dr. Miriam Martinez came to our meeting to speak about minor consent, she called Access to check on the CBHS policy and was told that minors could not call Access, this despite a 17-page policy that details under what circumstances minors may in fact call Access and ask for services.
- d. We received a complaint about veterans being told that they have to go to the VA hospital when in fact they can be accepted into treatment by CBHS.

What is being done to make sure that the Access phone lines are covered at all times during its hours of operation? What is being done to fix the long-standing problem with the telephone lines to Access?

Now that the Eligibility Team has been moved from Access to another location, how are eligibility determinations being made?

Dr. Katz: I can't answer those questions. This is the first I've heard of it.

Dr. Cabaj: Central Access is not under me anymore, so I don't have all the answers either. and I don't have the direct say.

Dr. Katz: Is this a technical issue about the phones?

Dr. Cabaj: We are working on a correction plan.

Mr. Casados: I work at the front desk, and there have been no calls bouncing back since the last time I raised the issue.

Mr. Medema: One of our questions is why Central Access is no longer under Dr. Cabaj.

Dr. Turner: This is a concern of ours. We meet with Bob once a month. It's frustrating when clients complain about Access. We just want to bring this to your attention.

Dr. Katz: You've got my attention.

Dr. Turner: Dr. Miriam Martinez who is one of the people who raised the issue for the Board is here tonight and I'd like to ask her for a comment.

Dr. Martinez: The issue was really raised by a group of teenagers. They were told they couldn't access services without parental consent. I was asked to come to the Mental Health Board to talk about minor consent issues. I called Access myself to see what the policy was.

Dr. Katz: That was very smart.

Dr. Martinez: I was told minors could not be referred directly and they have to have their parents call. So we had a discussion at the Board meeting about the circumstances under which minors can ask for and receive treatment without parental consent. It's important not to put blockers up for young people who are trying to receive mental health services. There are so many other blocks for them.

Dr. Katz: Absolutely.

Ms. Brooke: Janet Schallwitz called today and said that apparently the additional training done with Access has helped the process.

Dr. Katz: It sounds like your intervention helped.

Dr. Cabaj: Access recently hired a Spanish-speaking staff person, who has a background in working with children, and that will help, too.

Mr. Medema: What is the final decision-making process for Proposition 63 in San Francisco. Is it entirely up to the 41-member Behavioral Health Innovations Task Force?

Dr. Katz: You can't spend money in San Francisco without the Health Commission and the Board of Supervisors going along with it. But that being said, there is the power of consensus. If the 41 members come up with a plan and have consensus, then no one will want to touch it.

But if the process ends in discord then I think it goes way open. Barbara Garcia is very good at leading this kind of process. Hopefully, you can come up with a plan that is untouchable. But there are no promises.

The Health Commission can make changes. The Board of Supervisors does not vote on any of the contracts. But that being said, the Board could attempt to interfere. It could require certain expenditures. I think the Board will not want to do that. That will happen only if there is a lot of discord.

Mr. Medema: The MHB holds a final hearing on the plan. This is an entirely new role for the Board. What are your thoughts on the role of the MHB on the draft plan?

Dr. Katz: I can't think of a better group to do that.

Mr. Medema: Could you comment on the closing of St. Luke's inpatient psychiatric unit and the loss of those beds?

Dr. Katz: St. Luke's has announced that it's going to close their inpatient psychiatric unit on September 30, 2005. While it sounds greatly harmful, I'm not so sure it will be. They run a very small census. The average number of patients on that unit is 5-6. Think of general hospital and then compare that with a 6-person unit. I'm not sure with such a small number of patients, you can do a very good job. You could maybe do a fantastic job with a six person adolescent unit. But with only six people and the complete range of patients, I'm not convinced you can do such a good job.



This can be an opportunity. Part of what we are trying to do is decrease institutional beds. The City will spend less money, and look at alternatives. I feel it's too small a unit to do quality care. I don't see how you do cultural competency on such a small level.

Mr. Medema: There is word going around that all contracts whether or not they are up for renewal will be put out for bids. Is that true?

Dr. Cabaj: The talk is about rebidding all substance abuse services contracts. We're looking at the sequencing of that, and tying it in with the Mental Health Services Act and with the integration of services. I don't believe all services are being put out for bid.

Dr. Turner: Now I'd like to ask Board members for additional questions.

Mr. Casados: PES has taken the stance that unless you're suicidal, even if you're right on the line, they don't keep you anymore. I've taken friends in who have been on the edge of suicide and PES has sent them home.

Dr. Katz: I can't speak for PES, but I can only tell you my views. When you get to the clinical issues, it has to be the individual practitioner assessing the individual person. You want your treatment to fit the person.

Mr. Casados: These clients are not even being referred to ADUs, the Acute Diversion Units.

Dr. Katz: Then I would not support that. I'm not always convinced that an inpatient stay is always helpful to someone with psychiatric problems. I've seen that with my family members and with others. I tend to be more recovery-based and more focused on function. I want to know what people can do. What they can do to be healthy. I'm less interested in their diagnosis. Or what is the lab test.

PES should be sending people to the appropriate place. But it's also true, if you are overrun with people who seriously demand your help immediately, you may gloss over that. PES or some group needs to be able to take someone in crisis and offer the appropriate treatment.

Ms. Kellum-King: My son is 22, and he was in crisis. He went to the crisis unit and ended up in hospital. He was released with three medications prescribed. So his father and I took him to the clinic, and they refused to give him one of the medications. We called the prescribing doctor and he said, yes, that's exactly what I prescribed.

My son ended up back in the hospital. I'm concerned about the flow of communication. It was unnecessary for my son to go back into the hospital.

Dr. Katz: I'm very sorry to hear about this. Do you know the reason the clinic doctor said he wouldn't give the medication?

Ms. Kellum-King: The doctor in the clinic said he never gives any client two antipsychotics at the same time.



Dr. Katz: Doctors are a terrible lot for getting them to agree. Doctors are sometimes known for viciously attacking other doctors treatment plans. It's not unusual for doctors to believe opposite things. The problem with this is that the last thing a system should be doing is creating more havoc when someone's mind is already creating havoc. A system should operate like a system.

Where is your son now?

Ms. Kellum-King: He's in a board and care home.

Dr. Shukla: On the opposite side of the spectrum from dementia or psychosis, my questions are about more subacute, low-grade conditions. More and more, physicians are the first to be presented with mental illness, to diagnosis it and treat it, and they are not prepared and most of all they don't have time to treat it. Downstream, this leads to more public health effects, like loss of work time, poor parenting, poor condition of health, or diabetics not taking their medications.

Because it's not such a sexy, glamorous topic, the lower grade subacute mental illness gets missed. What are your thoughts on that level?

Dr. Katz: Those are great comments you've made. I think the primary care practitioners have to learn to be better at recognizing, diagnosing, and treating all levels of mental illness.

We shouldn't let them off by saying they don't have the time. They spend a lot of time on the person with GI scans and endocrine work ups. When all those tests are negative, when a more skilled person would have said this was more a mental health issue, then the doctor loses all interest, or they say you should see a mental health practitioner.

But they have spent a lot of time. I think the key issue is the training, and learning the skills involved in recognizing mental illness. They have to be part of the skill set of a primary care doctor. I trained as a primary care doctor. However as a primary care doctor, I can diagnose depression and anxiety and I can prescribe for those. Now, that doesn't mean I do all levels of prescribing. If I thought someone needed an anti-psychotic, then I would get a consultation or do a referral.

What you're raising, which I've never thought about that way, is the question of whether this a public health responsibility. It's a little scary, because sometimes just getting through one of my days, takes all the energy I have. There is responsibility with the medical residency and the licensing bodies. But looking at it as a public health intervention, you could do a lot of good, by helping a variety of practitioners. How would you go about doing that?

Dr. Shukla: I'm concerned that there isn't early intervention to prevent problems downstream.

Dr. Katz: Right, that's an important perspective. So first, we need to adequately treat people. I'm a good urban health practitioner, but not so good as a rural doctor. We do the things we're comfortable with. A separate thread is, What resources are there in the

mental health system? It's really systems that make communities better. What are the resources? Are we just working at the high end, and not focusing enough on keeping people healthy? And I think the answer is yes. This is also a Prop 63 question.

Ms. Walker: I turned on the TV to Channel 26 and you were talking to the Board of Supervisors and I didn't get your whole argument. It seemed to me you were giving an argument if you have limited funds, to put funds at the top of the pyramid at the expense of the bottom of the pyramid.

Dr. Katz: What I would say is that as a community, I would like to see us spend less money on hospitalization and more on community organizations. Because hospitalizations are not always therapeutic.

Dr. Turner: I wanted to follow up with respect to Prop 63. All of these ideas and what Jagruti was bringing up is about the philosophy of prevention and cultural competency and blending systems of care. We have been very disappointed on the Behavioral Health Innovations Task Force at the level of the state allocation. I'm very thankful that you will be talking with Dr. Mayberg tomorrow.

The State Department of Mental Health really feels the per capita amount is not a good argument. We have to think carefully about how we argue our case. Do you feel we are well prepared?

Dr. Katz: I think there is no chance they are going to take money from other counties to give it to San Francisco. But there is the reserve fund. And I think they are going to be having a huge amount of unspent money. A lot of counties don't have mental health systems. They just institutionalize people. So they can't spend all that money in accord with Prop 63. To spend money well and spend it right can be very difficult. Ultimately, they will have to do a new formula.

What I will emphasize with Dr. Mayberg is that I understand you will not be changing the formula, and I am not coming to whine or yell. But my goal is to find solutions. What is the problem we are trying to solve?

San Francisco has greater need and greater ability to create programs responsive to Prop 63 than is reflected in our award. And the ways they can deal with that is to look at money that is unallocated and to look at money that does not get spent and to look at formula changes.

I can think of one way to be responsive to us and not make a special allocation to San Francisco. They could set up a special fund, to fund treatment for specific persons. To me that would include people who are homeless, incarcerated, or recently incarcerated, or institutionalized. All such people deserve a plan. And Prop 63 is not about incarceration or institutionalization. This is like with long-term care. We would apply for the person. I just want to be told that for every person in my system, who I have a plan for, and who meets the criteria, we would get a set amount of money. I think San Francisco would do very well with that plan.

Mr. Douglas: Thank you. When you're thinking about the future, think about putting behavioral health and physical health under the same roof. My experience on the Mental Health Board is very frustrating because we find out about cuts after they have been made.

Dr. Turner: Dr. Katz, we thank you very much for being here.

## **2.2 Discussion of possible future actions related to the presentation.**

Mr. Douglas: I think we may have a budget committee, which I think I volunteered for, and maybe we should follow up, and be involved on a year-round basis.

Mr. Medema: There are other things that are happening, too. I had a brief conversation with Jim Illig, a member of the Health Commission. I will have more conversations with him about the MHB cooperating with the Health Commission on the budget.

Dr. Turner: What I heard Dr. Katz say is that this is a year-long process, and that we can participate through Bob and Barbara.

Mr. Medema: He was also saying the Board needs to make recommendations. I think we don't just want him to get our minutes. Let's come up with recommendations.

Mr. Casados: I think one recommendation is that we ask him to put Central Access back under Bob. I think it's important that we advocate for that.

Dr. Turner: Is that too much micromanaging?

Mr. Casados: Not at all. That's where it should be, because Bob runs the clinics Access is referring people to. If he is responsible for clinics then he should be in charge of what refers people to them.

Mr. McGhee: Dr. Katz spoke about the importance of the system working as a system.

Ms. Shaffer: We've been talking about different consumer issues and access to services and quality of care. I've been on the Board three years, and we're still talking about the same problem. We have to have some solutions. If we can't even discuss this and get problems solved, how are the consumers going to do it?

Dr. Moses: I still didn't hear an answer from him, who we send our recommendations to. We have a lot of issues.

Dr. Turner: You're right Toye, we should follow up on that. That should be clear.

Ms. Walker: Dr. Katz didn't explain why they made the change with Access.

Mr. Casados: Bob can't explain it.

Dr. Turner: I think since Bob reports to Barbara we need to ask Barbara that question about Access first.

Mr. Medema: I think it's important to keep in mind that Dr. Katz is the Director of Public Health. I'm not sure it's clicking in his mind about Access. He's the general, and he's not going to be aware of every decision made within his department.

I'd like to see the Executive Committee schedule in advance what time in the year we'd like to see him come to the Board and the Executive committee meeting. That was a very nice thing for him to agree to meeting with us.

Dr. Turner: When we can't have Bob here, could we have Barbara? We need someone at that level. And we can talk about changing our meeting time, to make it easier for Bob to be here.

Mr. Casados: Can we ask the Executive Committee to invite Barbara to come meet with us?

### **2.3 Public comment relevant to Item 2.0.**

Ms. Milfay: I'm a member of NAMI. I think there is a major disconnect, between the theory of the delivery care and practice. Cutting the number of acute beds will not cut back on the number of people who need acute treatment. My son has been denied admission.

My son has been hospitalized 29 times in the last three years. He referred himself for hospitalization, got denied, then got homicidal. He was told that the only way he could get services, is if he was homeless. The director of Progress Foundation was saying they have beds going empty but PES doesn't call them for acute diversion.

Veronika Cauley: I'm a nurse, and I work in methadone at Westside. I've applied to be on the MHB. I'm kind of perplexed when I hear you discuss these issues. When you have Mitch Katz right here in front of you, why you don't you lay the issues out crystal clear. When I was on the Ryan White Care Council, we did a prioritization from a bare bones budget to getting every dime we want. I deal with a lot of mental health clients. Why when you have people who can make change, don't you lay it on the line when you have them right here in front of you?

Mr. De Anda: I'm a consumer and a veteran. I'm glad Michael Medema put the issues on the table. I'm a man of action, too. I went to the state commission meeting, Mr. Darrell Steinberg heard my concern and is taking the lead to put veterans issues into Prop 63.

Mr. Pilpel: I suggest following up with a thank you to Dr. Katz, and recommending that Access be moved back under Bob, and asking who the MHB should send recommendations to, I think you have to keep this going.

Mr. Kalman: You read a lot about Prop 63. There is a document available at the Controller's office regarding uses of funds. There is an exact figure. All it says about prop 63, is \$207,487. Not even \$210,000. This needs some clarification. I have also the Mayor's budget. There is not one word about Prop 63. Probably everybody knows about the federal tobacco settlement. The settlement was for \$10 billion down from \$310 billion. What's going on? We need some clarification.

Ms. Santana Mora: The \$207,000 is just the planning money that the state gave us.

### Item 3.0 ACTION ITEMS

#### 3.1 Public comment relevant to Item 3.0

Ms. Walker requested that item 3,2,h be removed from the consent calendar.

#### 3.2 Consent Calendar

**3.2.a RESOLUTION (MHB-2005-19):** Be it resolved that the minutes of the Mental Health Board meeting of May 11, 2005, be approved as submitted.

(Passed unanimously.)

**3.2.b RESOLUTION (MHB-2005-20):** Be it resolved that the Mental Health Board grant leaves of absence for the meeting of June 8, 2005, to the following members: Benito Casados; Supervisor Bevan Dufty; Michael Medema; Toye Moses, Ph.D., M.P.H.

(Passed unanimously.)

**3.2.c RESOLUTION (MHB-2005-21):** To Commend Kalifa Coulibaly, Owen Spaulding, and Gregg Wozniak and present them with certificates as follows:

*The Mental Health Board of San Francisco commends*

**Kalifa Coulibaly**

*On May 9, 2005, at the time of a fatal shooting  
at the office of Conard House Community Services,  
you took immediate and effective action  
at great personal risk  
to control and disarm a dangerous and determined assailant,  
thereby saving an unknown number of lives.  
For your courageous action  
we give you our deepest gratitude.*

*The same certificate also for*

**Owen Spaulding  
Gregg Wozniak**

(Passed unanimously.)

**3.2.d RESOLUTION (MHB-2005-22):** To commend Officer Kevin Gotchet and present him with a certificate as follows:

**The Mental Health Board of San Francisco commends**

**Officer Kevin Gotchet**

*On May 9, 2005, at the time of a fatal shooting  
at the office of Conard House Community Services,  
you responded immediately,*

*assessed a complex situation accurately,  
and prevented any further tragedy from taking place.  
For this we give you our deepest gratitude.*

(Passed unanimously.)

**3.2.e RESOLUTION (MHB-2005-23): Be it resolved that the meeting notes of the Mental Health Board meeting of June 8, 2005, be approved as submitted.**

(Passed unanimously.)

**3.2.f RESOLUTION (MHB-2005-24): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of July 13, 2005, to the following members: Idell Wilson.**

(Passed unanimously.)

**3.2.g RESOLUTION (MHB-2005-25): Be it resolved that the Mental Health Board honors Linda Wang for her 34 years of service to the City. (Attachment B)**

*The Mental Health Board  
honors*

***Linda Wang***

*For over 34 years of dedicated service to San Francisco  
as a clinician and administrator  
in the many different incarnations of the mental health system.  
For your outstanding leadership  
as Director of Adult and Older Adult Services  
for Community Behavioral Health Services.  
For your integrity and for your kindness  
in dealing with clients, family members, staff, and the public.  
For championing innovative programs.  
For your calm demeanor in the face of serial crises.  
For being so accessible to the Mental Health Board  
and for being a steadfast supporter of our work.*

*We wish you the best as you leave behind  
piles of paperwork and relentless budget battles,  
and instead start taking classes for fun, traveling to new places,  
and spending lots and lots of time  
playing with your granddaughter.*

(Passed unanimously.)

**3.2.i RESOLUTION (MHB-2005-26): In opposition to the State allocation plan for the Mental Health Services Act**

WHEREAS, the Department of Mental Health of the State of California has approved an allocation plan for the Mental Health Services Act which gives the County of San Francisco the lowest per capita funding of any county in the state, and

WHEREAS, critical mental health needs named in the Mental Health Services Act were not taken into account in the allocation plan, and

WHEREAS, the allocation of the funding should be determined based solely on need and not on politics, now, therefore

BE IT RESOLVED, that the Mental Health Board of San Francisco endorses the allocation letter written by Belinda Lyons, Executive Director of the Mental Health Association, dated June 15, 2005, and adopts this letter as the official policy of the Mental Health Board, and

BE IT FURTHER RESOLVED, that the Mental Health Board commends Mayor Gavin Newsom, State Senators Carole Migden and Jackie Speier, Assembly Members Mark Leno and Leland Yee, the Board of Supervisors, Mitch Katz, Director of Public Health, and Barbara Garcia, Co-chair of the Behavioral Health Innovations Task Force, Robert Cabaj, Director of Behavioral Health, Belinda Lyons of the Mental Health Association, and the San Francisco Proposition 63 Campaign Committee for doing everything in their power to correct the allocation formula in order to bring it in line with the intent of the initiative and to bring San Francisco's share of the funding in line with the reality of the need for mental health services in our city.  
(Passed unanimously.)

Discussion of 3.2.h, a proposed resolution to state the Mental Health Board's concerns about the reduction of substance abuse funding.

Mr. Douglas: It seems to me that this is moot because the money has been restored.

Dr. Shukla: Is there any benefit to making the statement after the fact?

Mr. Medema: There is in letting the Mayor know where the MHB stands on taking funds away from substance abuse services. It's a way of saying this is not how we'd like to see you operate.

Ms. Brooke: You could have a resolution at the next meeting commending the Board of Supervisors for restoring the funding and that would show where you stand. (There was general consensus in favor of this.)

**RESOLUTION (MHB-2005-27) Be it resolved that the Mental Health Board disapproves the proposed resolution regarding the funding of substance abuse services.**  
(Passed unanimously)



### 3.3.a Resolution to amend the MHB Bylaws

Dr. Turner: The major change in the Bylaws is to bring the attendance policy in line with other MHBs around the state. During the audit when a couple of us met with chairs of other mental health boards, they were shocked that we would allow an unlimited number of missed meetings by a member as long as they called before the meeting. The San Francisco Administrative code says that a member cannot miss more than three meetings in a twelve month period unless they have been granted a leave of absence.

So, if a member has medical problems that will need attention, family or personal issues coming up that will make attendance impossible, they can call in advance and request a leave for up to two months. But the board is sensitive to the needs of its members, especially consumers and family members who may have unexpected crises making it impossible for them to attend the meeting. In those cases when something comes up at the last minute or for other reasons you just can't make it to a meeting, you can be absent three times in twelve months without losing your seat. However, it would be appreciated if you call Rich or Helynna to let them know so that we aren't holding up the meeting waiting for you to arrive to achieve quorum. Also, we care, so we would worry about you.

The reason the Executive Committee wants to make this change is to help the board to have quorum for its meetings and to encourage full participation by its members. One of the ways the Board is very effective is by passing resolutions on issues. Since resolutions have to come to the Executive Committee first, and then be approved by the full Board, it takes a few weeks as it is to pass a resolution. But if we don't have quorum for a meeting or two, by the time we pass the resolution, we may be too late to make a difference. For example, this agenda has all of the resolutions from the meeting in June.

We have also had several members over the past few years who have missed most of the meetings for a year but they have called, so they stay on the board holding a seat that could be filled by someone who would be an active member. Quorum is always nine members, so it is crucial that we have full participation by most of the members.

One additional change we need to make in the Bylaws is to remove the phrase 'either in person or by telephone,' from Article V, Section 5.a. That's because meetings by telephone are not allowed under the Sunshine Ordinance.

**RESOLUTION (MHB-2005-28):** Be it resolved that the Mental Health Board amend its bylaws as recommended by the Executive Committee to revise its attendance policy, to include the new mandate regarding the Mental Health Services Act, and to make additional minor changes. (Passed unanimously.)

### 3.3.b Resolution in opposition to Governor Schwarzenegger's special election.

Ms. Walker: I think the special election is bound to come like Christmas. I think this is moot.

Mr. Douglas: I think this is something we should not get involved in. We should focus on mental health and substance abuse.

Mr. Medema: As the person who proposed this, I still want to support it. The cost to the State for the special election is \$45 million. The Governor is calling it on his own. It is not mandated. The Governor is saying that the counties aren't going to have to pay for it. But counties will and it normally takes years to get reimbursed. The money spent on the special election could be spent instead on Mobile Crisis and the 24/7 Drop-in Center.

Ms. Walker: I agree with everything you said, but we are too late. The election has been certified.

Dr. Moses: I think I agree with my colleague Kate. It looks like the train has left the station. It's a very good idea. But I don't know whether we have the power to do that. To me it's a done deal.

Mr. Casados: It's not a done deal until September 1st. The Governor can still call it off before September 1st. If his ratings keep going down the way they are going down, he may call it off.

Mr. McGhee: It's not a done deal. And there is the possibility that Bill Lockyer is going to be filing a lawsuit. One thing I heard in the comments tonight is that the MHB is not fighting and not taking the action it needs to take. I know it's uncomfortable to fight. I think when you accept a seat on this Board you are agreeing to fight for consumers. I sit on the State Board of Psychology. I was appointed by the Governor, but that doesn't mean I always agree with him. This is not going to jeopardize anyone here.

Ms. Walker: If this not a done deal, then I'm withdrawing my opposition and would like to call for the vote as it stands.

**RESOLUTION (MHB-2005-29) In opposition to Governor Schwarzenegger's special election**

**WHEREAS, Governor Arnold Schwarzenegger has used special executive powers to declare a special election for California on November 8, 2005, and**

**WHEREAS, the items on the ballot for that special election will be five or more of the Governor's own initiatives, and**

**WHEREAS, this special election is seen by many Californians as a means for the Governor to do extensive fundraising and to further his own political ambitions, and**

**WHEREAS, the initiative process has never been used in this way before, and many Californians believe it was never intended to be used in this way, and**

**WHEREAS, two-thirds of Californians are opposed to this special election, and**

WHEREAS, the cost of this special election to California counties is estimated to be \$45 million dollars at a time of severe budget deficits, and

WHEREAS, the cost of this special election uses state funding needlessly when San Francisco, like other counties, is in desperate need of funds for housing the homeless, residential treatment facilities for the mentally-ill, outpatient programs for people struggling with substance abuse and alcohol abuse, outreach teams, increased mobile crisis services, a 24/7 drop-in center for people in crisis, and for many other urgent needs, and

WHEREAS, a regular election is scheduled for only seven months later in June 2006, and

WHEREAS, the issues set forth in the Governor's initiatives which will be on the ballot are complex and complicated issues and cannot adequately or realistically be addressed with a yes or no vote, and

WHEREAS, the initiatives on the ballot for the special election will have a profound impact on the future of California's political process and education system, and

WHEREAS, voter turnout for special elections is significantly lower than for regular elections, and

WHEREAS, many Californians view that the Governor is using the initiative process and his personal popularity to bypass the kind of serious democratic debate and detailed public input that his initiatives actually require, now, therefore

BE IT RESOLVED, that the Mental Health Board of San Francisco urges the Mayor and the Board of Supervisors to take a public position on behalf of the City and County of San Francisco in opposition to the special election being called by Governor Schwarzenegger for November 8, 2005, and

BE IT FURTHER RESOLVED, that the Mental Health Board of San Francisco urges the Mayor and the Board of Supervisors and other city leaders to speak out in opposition to the passage of the Governor's initiatives, not only on the basis of the content of those initiatives but as a matter of principal and as a matter of defending our democracy.  
(Passed unanimously.)

#### 4.0 MENTAL HEALTH BOARD COMMITTEES

##### 4.1 Report from the Executive Director of the Mental Health Board

Ms. Brooke: The 14th Police Crisis Intervention Training took place June 20-23.

The MHB Annual Retreat will be held all day on Saturday, December 3rd.

The MHB Annual Report for 2005 was posted on the Web at: [www.sfgov.org/mental\\_health](http://www.sfgov.org/mental_health). The Board of Supervisors passed a regulation saying that we are not allowed to use City money to pay for the printing of annual reports.

Mr. McGhee: How do they get the information out to people who can't go online? That's a disservice to the community we represent. The majority of the population of America do not use computers.

Dr. Moses: This is an important question, and I'd like to refer it to the Executive Committee.

#### **4.2 Report of the Chair of the Board and the Executive Committee.**

Dr. Turner: Helynna, LaVaughn, and I met with Dr. Cabaj, Pat Bennett, the Prop 63 Consultant, and Belinda Lyons of the Mental Health Association. They are supposed to get us the draft of the plan by August 23rd. We would hold the all day hearing on September 24. What we need to do in the next month is plan for the logistics.

The Executive Committee has decided to cancel the full Board meeting for August 10th. Instead on that same night we will hold two committee meetings, and we're asking everyone to attend.

There will be an Executive Committee meeting focusing on the hearing. And a Stakeholders Committee meeting to make sure that we get the word out and have the broadest possible participation.

#### **4.3 Other committee reports.**

No reports.

#### **4.4 Reports by members of the Board on their activities on behalf of the Board.**

Ms. Kellum-King: I paid a visit to the school district in regard to someone showing up for Proposition 63 meetings. They have a liaison person who should be showing up.

Dr. Turner: We noticed that there is no participation by SFUSD in Prop 63 planning at the Task Force level or at the subcommittee level.

Ms. Shaffer: I think that's a huge gap.

Mr. McGhee: What has been done to get them there? Has Arlene Ackerman been contacted or the president of the School Board?

Ms. Brooke: I can follow up with you about that.

Ms. Kellum-King: The information went out to everyone, but no one took responsibility

Ms. Shaffer: I will take that to the Community Advisory Committee.

#### **4.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.**

Dr. Moses: The Family Mosaic Project is one of our best projects. It's time to ask the ED to come present about all their activities. We have a new director of YGC. I think we need to

bring him here to talk to us about his plan. This is of particular interest to the Bayview Hunters Point.

Ms. Shaffer: There are some changes in the mental health section at YCG. In terms of agenda items, we need to connect with the school district.

#### **4.6 Public comment relevant to Item 4.0**

Mr. Pilpel: On the discussion of the certificate for the police officer, you might want to present it to him at a Police Commission meeting. With regard to the annual report, Administrative Code 1.57 says if a body has good reason to print an annual report, you can get a waiver from the Board of Supervisors. I've arranged for you to use Room 421 at City Hall on the second Wednesday of the month, if you want.

Ms. Walker: It would be good to change our meetings to a different Wednesday to make it easier for Dr. Cabaj to attend.

#### **5.0 PUBLIC COMMENT**

Mr. De Anda: I was here four months ago. I think the Board could take a little more of an advocacy role. You should be more vocal and less subservient and passive.

Mr. Kalman: Why don't we get the paperwork from the meetings of the other MHBs around the state to make a comparison of their work and our work. Like San Jose and Sacramento. I think it's more productive to have some experience from other Mental Health Boards. Also, I've heard from discussions between very high politicians, saying if we make our services very good, that means we are a magnet and everybody with mental illness or the homeless will come or be sent to San Francisco. If you would have a problem with your son, and you hear that San Jose or Sacramento is better, of course you would do everything possible to move to San Jose or Sacramento.

#### **7.0 ADJOURNMENT**

There being no further business, the meeting was adjourned at 8:55 p.m.





*Department of Public Health*  
**SAN FRANCISCO MENTAL HEALTH BOARD**

1380 Howard Street, Suite 510  
San Francisco, CA 94103-2614  
(415) 255-3474 fax: 255-3760  
TTD: 255-3449  
mhb@igc.org  
[www.sfgov.org/mental\\_health](http://www.sfgov.org/mental_health)

DOCUMENTS DEPT.

AUG 01 2005

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*Agenda*

**The Mental Health Board meeting  
scheduled for  
Wednesday, August 10, 2005,  
has been  
CANCELED**

*Agenda cancelled*

The next meeting of the full Board will be Wednesday, September 14, 2005, in Room 537 at 1380 Howard Street. An agenda for that meeting will be sent out at the beginning of September.

The following committees will meet on Wednesday, August 10, 2005, at 6:30 p.m. at 1380 Howard Street:

The MHB Executive Committee - 5th Floor Cafe  
The MHB Proposition 63 Stakeholders Committee - Room 537

The agendas for the committee meetings will be posted on the MHB website ([www.sfgov.org/mental\\_health](http://www.sfgov.org/mental_health)), at the Government Information Center at the Main Library, and with the Clerk of the Board of Supervisors.





# Concerned about Mental Health?

Come join a community meeting about how to improve Mental Health services in San Francisco through the Mental Health Services Act. Let your voice be heard in the development of recommendations to expand and transform San Francisco's Mental Health System

**The Behavioral Health Innovations Task  
Force will be meeting at:**

Visitation Valley Middle School  
450 Raymond  
Thursday, August 4  
4:00 pm – 7:00 pm

This is your opportunity to let the Task Force know what mental health issues are important to you. Public comments will be taken during the first two-hours of the meeting.

**Your input can make a difference!**

This meeting is wheelchair accessible. Assistive Listening Devices, materials in large print and other alternative formats, American Sign Language interpreters, and other accommodations will be made available upon request. Contact Ladonnis Elston at 255-3444 (V) or 255-3745 (TTY). Providing at least 72 hours notice will help ensure availability. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illness, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based scented products. Please help the City to accommodate these individuals.

For information on other ways to get involved, visit our website at:

**[www.sfdph.org/Prop63](http://www.sfdph.org/Prop63)**





## San Francisco Proposition 63

### Public Comment Form

The goal of Proposition 63, the Mental Health Services Act, is to increase the availability of prevention and early intervention mental health services that are innovative, based on recognized best practices, and cost effective. San Francisco has established a 40-member Task Force to develop and submit a 3-year plan for meeting this goal to the State. The Task Force is welcoming ideas and comments through public meetings and at: [www.dph.sf.ca.us/Prop63/default.htm](http://www.dph.sf.ca.us/Prop63/default.htm). You may also use this form to submit your ideas.

Issue/Topic Area: \_\_\_\_\_

Please let us know any Information or Ideas that you would like the Task Force to consider

Additional Suggested Data/Resources for Task Force

Other Comments

Contact Info: (Optional)\*

Name: \_\_\_\_\_

Organization/Affiliation: \_\_\_\_\_

Phone and/or E-mail Contact: \_\_\_\_\_

- Because of the many responses expected, we cannot respond to each comment submitted. Public meetings will be held throughout the process. Please see: [www.dph.sf.ca.us/Prop63/default.htm](http://www.dph.sf.ca.us/Prop63/default.htm) for details and more information about Proposition 63.

RETURN THIS FORM TO: Edwin Batongbacal, Department of Public Health  
1380 Howard Street 5<sup>th</sup> Floor  
San Francisco, CA





## SAN FRANCISCO MENTAL HEALTH BOARD

Gavin Newsom  
Mayor

1380 Howard Street, Suite 510  
San Francisco, CA 94103  
(415) 255-3474 fax: 255-3760  
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www.sfgov.org/mental\_health

### MEETING OF THE MENTAL HEALTH BOARD

Wednesday, September 14, 2005  
City Hall, 1 Dr. Carlton B. Goodlett Place  
4th Floor, Room 421  
6:30 p.m.

### AGENDA

#### CALL TO ORDER

DOCUMENTS DEPT.

#### ROLL CALL

AUG 30 2005

#### AGENDA CHANGES

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#### Item 1.0 DIRECTORS REPORT

For discussion.

06-30-05 10:02 AM RIVE

##### 1.1 Dr. Robert Cabaj, Director, Community Behavioral Health Services

A report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

##### 1.2 Public comment relevant to Item 1.0

#### Item 2.0 PRESENTATION

For discussion.

##### 2.1 Overview of the Mental Health Services Act (Proposition 63) Draft Plan

Barbara Garcia, Director, Community Programs, Deputy Director of Public Health, and Co-Chair of the Behavioral Health Innovations Task Force

##### 2.2 Discussion of possible future actions related to presentations

##### 2.3 Public comment relevant to Item 2.0

#### Item 3.0 ACTION ITEMS

For discussion and possible action.

##### 3.1 Public comment relevant to Item 3.0

##### 3.2 Consent Calendar:

3.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of July 13, 2005, be approved as submitted.

#### **Item 4.0 REPORTS**

For discussion and possible action..

4.1 Report from the Executive Director of the Mental Health Board

4.2 Report of the Chair of the Board and the Executive Committee, including a report on the status of Proposition 63 planning and hearings to be held by the Mental Health Board. Discussion regarding the Board member roles in the upcoming hearings.

4.3 Stakeholder Committee Report

4.4 Report by members of the Board on their activities on behalf of the Board.

4.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

4.6 Public comment relevant to Item 4.0

#### **Item 5.0 PUBLIC COMMENT**

Members of the public may address the Mental Health Board on any items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board.

#### **ADJOURNMENT**

##### **DISABILITY ACCESS**

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD). Five days notice before the meeting will help to ensure the presence of an ASL interpreter or sound enhancement system. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.
2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and 14 Mission. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.
3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley which runs on the opposite side of the building from 10th Street.



4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

### **POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES**

The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

### **KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE**

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Adele Destro  
Sunshine Ordinance Task Force  
City Hall, Room 244  
1 Dr. Carlton B. Goodlett Place  
San Francisco, CA 94102-4689  
Telephone: (415)554-7724  
Fax: 4(15) 554-5163  
E-mail: [sotf@sfgov.org](mailto:sotf@sfgov.org)

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from Ms. Hall, or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: [www.sfgov.org/sunshine.htm](http://www.sfgov.org/sunshine.htm)

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: [www.sfgov.org/mental\\_health](http://www.sfgov.org/mental_health). You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

### **Lobbyist Registration and Reporting Requirements**

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site [www.sfgov.org/ethics](http://www.sfgov.org/ethics).



## Mental Health Board

September 14, 2005

### ADOPTED MINUTES

#### Mental Health Board

Wednesday, September 14, 2005  
1380 Howard Street, Room 537  
San Francisco, CA 94103  
6:30 p.m.

This meeting was held at City Hall, Room 421

**BOARD MEMBERS PRESENT:** Rebecca Turner, Ph.D. (Chair); Benito Casados; Bob Douglas, J.D.; Supervisor Bevan Dufty; John Kevin Hines; LaVaughn Kellum-King; James Shaye Keys; Claudia Lebish; James L. McGhee; Dorothy Shaffer, R.N., N.P., M.S.N.; Jagruti Shukla, M.D., M.P.H.; Kate Walker; Lisa Williams; Idell Wilson.

**BOARD MEMBERS ABSENT:** Michael Medema; Toye Moses, Ph.D., M.P.H.

#### PRESENTER:

Barbara Garcia  
Director, Community Programs  
Deputy Director of Health

**OTHERS PRESENT:** Edwin Batongbacal (Director of Adult Services, Community Behavioral Health Services); Ray Balberan (Mission Community Response Network); Emeric Kalman; Philip Rambo (SEIU Local 790); Andrew Sullivan; Sid Romyn; Helynnna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

#### CALL TO ORDER

The meeting was called to order at 6:35 p.m. by Rebecca Turner, Chair.

Dr. Turner: I'd like to welcome James Keys to our Board. He was appointed by Supervisor Chris Daly to a Public Interest Seat.

#### ROLL CALL

#### AGENDA CHANGES

Dr. Turner: We will be taking the presentation by Barbara Garcia first tonight, but apart from that change we will continue with the agenda in order.

#### 2. 1 PRESENTATION: Overview of the Mental Health Services Act (Proposition 63) Draft Plan

Dr. Turner: I'm delighted to have Barbara Garcia here tonight. She is the Director of Community Programs for the Department of Public Health, and Deputy Director of Health. She is also in charge of the Proposition 63 planning process.

Ms. Garcia: I want to thank the Mental Health Board for all your leadership during this process. Let me give you a little bit of the overview of the process. We were asked by the State of California to engage in a pretty deep planning process and they gave us a

very short period to do our work. We had a 41-member Task Force which met seven times in different communities. And we had 11 subcommittees which met five times each. So we had over 60 meetings. We received 85 position papers, and over 2,000 people were involved in the process.

At this point we're planning clinical services for 1) adults, 2) older adults, 3) transition age youth, and 4) children, youth and families.

Our goal is to submit the plan for San Francisco to the State by the end of October. Our plan is to be done with the final draft plan by September 20th. At that time we will turn it over to the Mental Health Board, which as you know, then takes it for a month. We will also submit it to the Health Commission at the same time. They have scheduled a hearing for October 18th.

At the same time we will be submitting a resolution to the Board of Supervisors and they will schedule a hearing.

What we've determined will be the State allocation for the clinical part of Proposition 63 is \$5.3 million. This is not a lot of money, and the State decision about the allocation was disappointing, because we have 50 different initiatives we'd like to fund.

Some of us went to Sacramento and talked with the State Director of Mental Health, Stephen Mayberg. We explained that we felt the allocation to San Francisco was low, and that there was no formula for including the homeless. And we have the lowest per capita rate of any county in the state. Dr. Mayberg was very interested to hear that we had a much larger capacity to provide services.

We believe we have a capacity to use \$20 million of Prop 63 funding. And we will go back to the State for additional money.

There are two pots of money. First there is money for full service partnerships, and this is 51% of the funding. The State is asking for wraparound services, whatever it takes, for people to achieve recovery and stabilization. We anticipate \$20,000 on average per client. Those dollars can pay for whatever it takes, such as housing or substance abuse treatment.

The next pot of money is for system development. In that area, we have tried to be fair to every population, but according to the data, there are two populations which are under-served: Transition age youth and older adults.

So the distribution of funds is:

Transitional youth, 30%  
Older adults, 30%  
Children, youth and families, 20%  
Adults, 20%

The Children, Youth and Families Section provide services in the schools. We want to respond to the issue of violence in the communities and the impact on families and support trauma recovery services.

We're looking at targeting senior centers. With regard to transitional youth, we're going to focus on cultural and ethnic groups, and youth-run organizations.

We're focusing on recovery, consumer involvement, and family involvement. We want to incorporate consumers into every aspect of our services.

We don't know if the State will accept our proposals. When the State gives approval, then we will go through the Request for Proposal (RFP) process for distributing the money.

Mr. McGhee: With Katrina happening, is there anticipation of the possibility of people coming into the San Francisco from the Gulf Coast. What's the potential impact, what is the possibility of budgeting more money for this?

Ms. Garcia: This is a new issue. We have people who are coming on their own to San Francisco. We've already processed over 500 families in the Bay Area, and about 50% of those are in San Francisco. We have set up a Service Center at St. Mary's Cathedral. We will continue to have a Service Center at the Red Cross and an office at City Hall.

FEMA will determine in the next couple of weeks whether they will actually move people here. Initially we were scheduled for 300 people, but FEMA delayed that. They did not want to move people so far from the Gulf Coast.

Mr. McGhee: Is there a plan being developed now in case FEMA does make money available?

Ms. Garcia: We haven't seen that yet, but that is something to plan for and we need to keep in mind how Proposition 63 might figure into that.

Mr. McGhee: It would make sense to me to have a plan ready to implement.

Ms. Garcia: I'll ask Edwin to bring that up with Bob Cabaj. That's a great idea.

Mr. Batongbacal: FEMA has approved plans for providing crisis counseling. So it is something to consider if more refugees will be coming in to San Francisco. San Francisco may be reimbursed for this.

Mr. McGhee: The reason I bring this up is that I sit on the State Board of Psychology, and we've been talking there about preparing right now and identifying clinicians right away.

Ms. Garcia: We do have the experience of Loma Prieta.

Mr. Keys: Ms. Garcia, you had mentioned you were looking at the homeless and homeless families and children. But you didn't mention families with children in SROs; they've been left out of the equation in San Francisco. There is an average of 2.3 children per family. The Bessie Carmichael school has 75% of families that live under poverty level.

Ms. Garcia: My deputy in the Department of Public Health put together the survey and census of SRO families, so we have a great interest in that issue. We will write out RFPs so people can apply. Homeless families are definitely a target for us. But for Proposition 63 funds to apply we have to be addressing the seriously mentally ill.

Mr. Keys: Prevention is supposed to be a key factor, and it would be important to prevent the hardship that these families go through.

Ms. Garcia: We have another \$4 million coming from the State under Proposition 63 that targets prevention, but we haven't gotten the guidelines from the State for that funding.

Mr. Keys: I would like to be kept up to date on that.

Ms. Garcia: We will be working with the MHB on that. And we will be looking for people to be on the RFP panels which will be selecting the programs which will be funded.

Dr. Turner: The Behavioral Health Innovations Task Force will continue to meet and will keep the MHB clued in.

Ms. Garcia: The State wants us to transform the system, and the Task Force has gelled and we want to keep them involved in the process.

Mr. Douglas: Is there a proposal for a 24/7 drop-in center and more peer support and peer-run programs?

Ms. Garcia: We couldn't fund a full 24/7 service because of the cost. We believe strongly that we have to have as much peer involvement as possible. We believe consumers and family members should participate in developing the process.

We funded a peer-driven model for older adults. But each of these things need to be designed in detail. I'm going to push to pay for peer advocates to be involved in the planning of the actual programs.

Today we met with three programs in the Tenderloin that have peer programs. Lots of people were interested in the 24/7 program, which would be peer-driven. But we're going to be getting more money down the road. These priorities you're talking about are not going to go away. And the 24/7 center is a priority that will continue. And we look to the Mental Health Services Act, the General Fund, and outside funding for these priorities.

Mr. Casados: You devoted 20% for adults. I know the heart and soul of Prop 63 was to reach adults, and to reach mentally ill in jail.

Where did the Task Force come up with such a screwed up allocation? Granted young adults and transitional adults need help, but what about those of us already living in the system and having to survive? There aren't enough housing units, so even if you fund enough for transitional youth, when they come into our system, there won't be enough services for them.

Ms. Garcia: I understand what you're saying. We have needs in every population. When we looked at the data, transitional youth and older adults were the most underserved in the system as a whole. And the difference in allocation amount is only 10% so that's only \$2-300,000.

I'll take your critiques to heart. One of goals in focusing on transitional youth is to reduce the number of people coming into the adult system. And overall there were more needs in each population than we could fund.

Mr. Casados: There are consumers like me who are going to end up back on the streets. The plan is flawed.

Ms. Garcia: I will take your criticism though I disagree with it. There is not enough money for any of the populations. I believe San Francisco deserves four times the amount of money we got. I predict the formula for allocation will continue to be fought. If the formula were based on a formula to include the homeless we would get more millions.

The MHSA is just part of the money we will be using to transform the whole system with the other \$200 million.

Miss Garcia: Jail services were a big highlight of the Task Force discussions. One of the State guidelines was not to help people in jail, but to focus on people getting out of jail. We had the Director of Jail Psych Services on the Task Force. I anticipate we will be able to fund some of those services.

Ms. Lebish: Mayor Newsom floated a trial balloon some months ago about suing the State around the allocation for more funds. I would like your opinion on that. Do you see that as something viable?

Ms. Garcia: We want to exhaust all administrative processes first. We want to keep a good public reputation for Proposition 63. At the same time we are working to increase our San Francisco allocation. Dr. Katz, myself, Dr. Cabaj, and our City lobbyist went to Sacramento to meet with Stephen Mayberg and Darrell Steinberg.

There is a set aside pot of money which will grow in the next few years. Some counties will not be able to spend all of their money. Many of the counties will have money left over. We've asked about the set aside and the unexpended funds.

So when we submit our plan we are going to show how we could spend additional money. I believe we can change the formula through the political process. Suing is not out of the question, but we want to exhaust all other possibilities.

This is an all new process so the State Department of Mental Health is struggling to manage this. This State department works closely with the California Mental Health Directors Association.

At that level, we pushed for the San Francisco allocation to be increased and LA got mad at us. So we have to be very mindful of the way we're doing this. We are continuing conversations. We have to concentrate on our own document, to show how many people we could serve with more money.

We have 1,000 new units of housing are ready to come on line in San Francisco, but we need supportive services.

Mr. Batongbacal: The State would like to allow counties to roll over some funds, but if there is too much accruing, the State will make a formula for taking it back.

Ms Garcia: We want to spend our dollars quickly and effectively to show the State that we can use more.

Dr. Shukla: Is there money set aside for analysis and data collection, in addition to qualitative evaluation? Quantitative analysis is needed to show how effective the program is.

Ms. Garcia: Not as yet. We probably will have to do this as a regional effort. We have talked internally about how we are going to evaluate ourselves. The State gave us planning dollars, but not evaluation dollars. I've gotten some calls from foundations interested in supporting this. We have not been allocated money for that purpose so we will have to do that out of our own resources. We might work with the regional group of directors to raise money together for this.

Dr. Turner: How much will this money be able to be trackable as apart from the rest of the mental health money?

Ms. Garcia: Each RFP and contract will be identified separately, but the hardest part will be in the area of full service partnership, because we want to have full flexibility for the programs, but we are working on tracking the funding specifically.



Dr. Turner: This Board has on several occasions has had a lot of concerns about Access, and we've received complaints about Access.

Ms. Garcia: I've been working on Access issues for several years. We transferred Access and Placement to put it under my division. One of the reasons to do this was in anticipation of integration. There are two things we're doing. First, we are opening up walk-in clinics to allow people to come in for access, and not just have access over the phone. Also we can't do eligibility over phone. So we're opening two sites on Howard Street.

We wanted to combine staff so that access and eligibility for everything is integrated.

For example with placement, where before placement was only mental health placement under Access, we knew that placements were happening throughout system. We get people referred from medical clinics, Psychiatric Emergency Services, and substance abuse programs, so now we can include all these programs under Access.

Right now no one can tell you where we have our empty beds in DPH. So we are trying to develop a system for tracking this.

When we took over Access there were lots of complaints and we were trying to address that.

Dr. Shukla: Drop-in is very important. But often people with mental illness can't make it in. Will the phone system still be in place? Will it be improved in parallel?

Ms. Garcia: Yes, the phone system will still be in place, and we are working on improving the phone system including the technical side of the phone system so calls don't get dropped. But we found the lack of face-to-face was also having impact. And we have a lot of drop-ins already at 1380 Howard of people seeking services.

Ms. Kellum King: My son was released from the hospital. He went to a clinic and they refused to give him medication because they had no information on him and no way to get it. I think it would be very important for any clinician to be able to go into the computer and see what the record is for anyone in the system.

Ms. Garcia: This has been a very frustrating thing. It's in process now with a company that is up grading our computer system. We want to connect the jail, primary care, SFGH, along with CBHS. This is one of the largest computer companies in the world and they haven't quite figured out how to add in CBHS to the system. Our CBHS system is purely a billing system, not a clinical system like what you're talking about.

We hope that down the line, we'll have \$10 million to put into our new medical systems. We have been advocating internally for a better CBHS system. Our system is outdated. They don't have replacement parts for some of the computers. Recently the same system in Santa Barbara went down and we don't want that to happen here.

We know that 40-70 of the people in primary care and acute health clinics have behavioral health issues. It's really essential to get this system working.

Mr. Casados: Friends of mine and I have called Access to get help for someone we know. Instead of being kicked to Mobile Crisis we've been kicked back upstairs at 1380 Howard to call the OD (Officer of the Day). Access should be able to direct people right over to Mobile Crisis. And these people are in real, real crisis, needing to see someone right away. Access should send them over to Mobile Crisis directly.

Dr. Turner: Thank you so much for being here and providing information to us. And for

opening the door to coming back again in the future.

Barbara's leadership throughout this process of planning for Proposition 63 has been great. It's been an incredible challenge, selecting people for the Task Force and designing the process. We appreciate how you've included us as partners in this process and we all want this to continue. It's awesome what you've done.

Ms. Garcia: I appreciate the leadership you and Idell and Michael have brought to the Task Force, and especially addressing the question of how do we serve consumers and involve them in the process. And thank you to Supervisor Dufty for supporting us through this process.

*Returning to the original order of the agenda:*

## **1.0 DIRECTORS REPORT**

### **1.1. Report from the Director of Community Behavioral Health Services**

Mr. Batongbacal reported for Dr. Cabaj: Much of the most important news was related to you by Barbara regarding Prop 63 and Katrina.

Community Behavioral Health Services has organized to be ready if more Katrina evacuees come to San Francisco. We have been deploying clinicians to the St. Mary's Service Center, and that includes providing clinicians for night shifts. We've had to use crisis skills as well as cultural competency training and experience. Some of our contractors, like Westside and the Bayview Hunters Point Foundation with experience in African American communities have been especially involved. Asian contractors have been working with Asian families.

In response to Benito's concern, there is \$35 million set aside, and they will use that for counties that can demonstrate extra need and the capacity to provide services. Some people are calling that set-aside the "San Francisco money." In the allocation formula the State did not include the homeless. But 70% of the homeless are in the central cities. Only a small proportion are in rural or suburban areas.

We're entering our second year of integration efforts and working with Zialogic, and with the group of change agents who are leading the integration efforts.

All programs applying for Mental Health Services Act money will have to demonstrate that they have relationships with agencies or have in-house ability to provide services on all three levels, mental health, substance abuse, and primary care.

The EPSDT audit is coming up. That's for our Early Prevention Screening Diagnostic and Treatment programs. We're auditing 100% of our civil service billings to prepare for the audit. We gave our contractors the tools to audit all of their own files. The State will give us two weeks official notice before they start the audit.

The gun violence project is continuing. Charley Morimoto and other DPH staff are working on responding to assist families when they are impacted by gun violence. On Labor Day weekend, I worked the weekend for Charley, and there were nine shootings with five homicides. Our team went out to help the families.

Supervisor Dufty: With regard to the supportive housing for people with long-term alcoholism, how will the referrals be handled?

Mr. Batongbacal: Through Marc Trotz and the DPH housing office. They've already identified three or four facilities they'll be working with.

Mr. Casados: What wrap-around services are going to be provided?

Mr. Batongbacal: I don't know if they've come up with a plan yet, but usually case managers are provided to problem solve anything that comes up so people can stay housed. This is something we're doing throughout the whole system. And this is something identified by the Prop 63 Task Force that they would like to expand in the system.

The written Director's Report was distributed:

**SF Prop 63 Plan.** DPH/CBHS staff, with assistance from Resource Development Associates, is currently drafting the 3-year Program and Expenditure Plan to be eventually submitted to the state Department of Mental Health (DMH) to access \$5.3 million per year in funding to implement Community Services and Supports under the Mental Health Services Act (MHSA). The draft Plan will soon be presented to the Health Commission and to the Mental Health Board, and will be made available for at least 30-days of public review, after which public hearings required under the Act will be held by the Mental Health Board for comments on the Plan prior to finalization and submission to the state. The draft CSS Plan will be based on the priorities and strategies identified by the extensive community planning process, spanning several months since the beginning of the year, led by the San Francisco Behavioral Health Innovations Task Force. Please stay tuned for the release of the draft Plan, and for information about the public hearings by the Mental Health Board. Information will be posted at the San Francisco MHSA website at: <http://www.dph.sf.ca.us/Prop63/default.htm>

It will take the state about 3 months to approve CSS plan submissions before it can start releasing funds to the counties. Start-up of MHSA services in San Francisco is therefore not anticipated until sometime early 2006, especially with additional time needed for provider selection, set-up and contracting processes.

Counties are allowed to request to use a portion of their 05-06 CSS funds for start-up expenditures, including for extension of community program planning and one-time system improvements. Also, DMH intends to issue guidelines on how counties can apply for CSS funds set-aside at the state-level, totaling \$35 million, for expanded services in counties demonstrating need and capacity, for statewide and regional strategies, and for prudent reserves.

**CBHS assists Katrina evacuees in SF.** Over the past week, the Department of Public Health and CBHS staff, in coordination with SF Human Services Agency and CBHS contractor agencies, have been assisting evacuees from Hurricane Katrina coming in to the American Red Cross (ARC) service center at St. Mary's Cathedral. About 350-400 evacuees have been assisted at the San Francisco ARC service centers, so far.

Services provided to the evacuees include: temporary accommodations in a hotel; medical and mental health screenings; cash assistance through CalWORKs/Temporary Assistance for Needy Families Program; health care coverage through the MediCal or Healthy Families Program; food stamps, child care; senior services; access to employment training programs and assistance with job placement; school enrollment; and support through the Social Security System. Planning for long-term housing for evacuees is now also taking place between the Mayor's Office of Housing and other participating agencies.

Flights of evacuees out of the hurricane disaster area have been temporarily suspended. Discussion is now taking place about how long to keep the St. Mary's Cathedral service center open.

Thank you to all who have helped in assisting the evacuees.

**San Francisco Gets Housing Grant for Homeless Alcoholics.** San Francisco has been

awarded by the U.S. Department of Housing and Urban Development (HUD) with a \$1 million grant per year to fund 60 permanent supportive housing units for chronically homeless individuals who are addicted to alcohol. 10 other cities also received awards, most of which are communities committed to jurisdictional 10-Year Plans to End Chronic Homelessness. HUD's new Housing for People Who Are Homeless and Addicted To Alcohol program will benefit 555 persons across the country, who are living on the streets for at least 365 days over the last five years and who also have a long-term addiction to alcohol. In San Francisco, the housing units will be implemented by DPH Housing and Urban Health, starting by about November.

## **1.2 Public Comment relevant to Item 1.0**

Mr. Kalman: I would like a report about the Mental Health Rehabilitation Facility and the displaced patients. How will they be treated?

Mr. Batongbacal: I don't know the answer to that. But I can talk to Liz Gray who's in charge of placement and then get back to you.

Mr. Balberan: I'm a representative of Mission Community of the Community Response Network of San Francisco. We are community-based services made up of Mission Neighborhood Center, Boys & Girls Club, Arriba Juntos, Instituto Familiar de la Raza., and St. John's Education Thresholds Center/Community Bridges Beacon.

All these organizations came together to form the Community Response Network. We came together because of the youth violence in the community. We are going submit a needs assessment so you can see how youth violence has impacted us. We've been supported by Barbara Garcia in participating in the Prop 63 process. What we're here for is for you to acknowledge that violence is a public health issue. But we need to make it clear that violence is a public health issue. And we need some political push on this.

We'd love for you to support the full service programs that hopefully will be outlined in the draft. Full service partnerships would help us greatly in the community. These agencies have been in the community for years. We want to expand our services.

Violence is a public health problem. You're the front lines of giving us the best help.

We feel in the African American community and Latino community, that the current budget of DPH is not addressing prevention. It's only 2% of a billion dollar budget.

Mr. Batongbacal: I was really excited to attend the conference of the California Mental Health Policy Forum. The theme of that conference was prevention. They had a Latino keynote speaker from a city on the East Coast where they had lots of gun violence, but they instituted a program that worked very well.

We're still dealing with just the end result in San Francisco, and that's valuable work, but it's not prevention. When the additional prevention money comes from the MHSA, that will open exciting possibilities for doing prevention.

Mr. Pilpel: I have public comment on Barbara Garcia's presentation. I think public comment should have been taken closer to her presentation so it would be more relevant.

Regarding the use of the funds and whether counties can expend the funds on a timely basis, there are three possibilities: 1. The State gives the money directly to counties. 2. Counties front the money and the State reimburses them. 3. The State allocates funding for specific purposes, encumbers and authorizes it for specific period. If it is not spent, then it reverts back to the State. I don't know how these funds are set up. That might be a relevant issue that you could find out about.

## 2.2 Discussion of possible future items related to presentations.

Dr. Turner: I would like to ask Board members for your response to Barbara Garcia's presentation and about our preparation for the Mental Health Board hearing.

Supervisor Dufty: I want to see if we can do this in the Board of Supervisors chamber and would like to see it televised on Channel 26. Since they replay hearings, more people would get to see the hearing.

Mr. McGhee: I think that's an excellent idea about the hearing being televised. There are people who are handicapped who can't make it down to City Hall.

Supervisor Dufty: It also goes online, so you can watch it from anywhere in the country.

Mr. Casados: I would ask that there would be a number available for phoned in comments from people.

Dr. Turner: That's an excellent idea.

Mr. Douglas: The Mayor's Council on Disability has a live phone line where you can call in during their meetings.

Mr. Casados: Could we do something like that?

Dr. Turner: Why not?

Mr. Casados: We want the opinion of as many people as possible. We could take a certain number of calls on the phone. We all know that the providers are going to be there. And we want to get some actual public comments besides the providers.

Dr. Turner: I want to remind people that we're going to have a very busy October. We need to have a quorum at our hearings and meetings. When the public makes the effort to come out, we need to be there to hear them. Then we need to meet to make our recommendations. Should we do that together or in committee meetings?

Mr. McGhee: It makes sense to have the committees make recommendations to the Board.

Dr. Turner: So committees could meet, pull together data, and make recommendations for the Board to vote on.

Dr. Shukla: It would be good to have the comments for our review before the committee meetings.

## 2.3 Public comment relevant to Item 2.0

Mr. Rambo: I was led to believe that with Prop 63 that you had to have new programs to use the money. I thought we got \$50 million.

Dr. Turner: We got \$5.3 million. We got way less money than we thought San Francisco was going to get, because of the way the formula was set out.

Mr. Rambo: I know Steve Fields. He did some of the writing of Prop 63. It said the money had to be used for new programs.

Dr. Turner: The idea is you want innovative services and community input. We had a very large community input process. It's not necessarily that a program has to be a brand new program, but we want to fund what's working and involve consumers and

family members.

Mr. Keys: Did LA include their homeless in their count? They have a huge homeless population, but theirs differs from ours. It's more because of lack of jobs.

Dr. Turner: I don't know the answer to that, but it's a good question though.

### Item 3.0 ACTION ITEMS

#### 3.1 Public comment relevant to Item 3.0

No public comment.

#### 3.2 Consent Calendar

3.2.a RESOLUTION (MHB-2005-30\_): Be it resolved that the minutes of the Mental Health Board meeting of July 13, 2005, be approved as submitted. (Passed unanimously.)

### 4.0 MENTAL HEALTH BOARD COMMITTEES

4.1 Report from the Executive Director of the Mental Health Board  
Announcement of upcoming events.

4.2 Report of the Chair of the Board and the Executive Committee  
No further report.

#### 4.3 Stakeholder Committee Report

Ms. Williams: At the Stakeholders Committee, Alicia and Antonio from the Mental Health Association talked about the outreach they did for the Task Force and Committee meetings, and they'll be doing a lot of the same things for the hearing.

The Committee wants to make sure there is outreach to church groups and the media, and that there are flyers in different languages. It's good that we'll be having a hearing in the southeast part of the city.

Mr. Hines: The flyers have to be in every language, on poles, on billboards, on TV.

Mr. McGhee: My father was a minister. Most all churches have newsletters, and they are very adamant about putting items into newsletters for their members on Sunday. You might want to actually meet with some of the ministers, especially those in the southeast part of the community.

Mr. Keys: In Supervisor Daly's office, we are putting out a newsletter, and we have inserts we put in. In reaching out to different cultures in District 6, Vietnamese, Filipino, Russian, African American, each has their own type of sensitivity. Some of the community centers would be a good place to go and find people who can translate what you want to say into the proper phrases. Just doing a direct translation will not be enough.

Dr. Shukla: We need to make sure all groups are represented. But also we need to have some sort of summary they can look at that the average person can understand. Something that's very user friendly. And internet availability. We need a snapshot of the whole report, because many people will not have time to read the whole report.

Dr. Turner: The biggest criticism from the Task Force was that the draft report was not user friendly; it was bureaucratic. Idell led the way in saying that this document was not going to be read by people. We suggested that they lay out in just 3-4 pages

the key allocations of the money.

Ms. Wilson: I was thinking to talk with the community leaders and inform them so they in turn can let people know. People who don't know how to read period are just lost. We need to find a way to get the information to them. And the consumers are the people we're supposed to be helping. I sit on the Task Force, but I'm lost with that report.

Mr. Douglas: I think it might be a good idea to have a pre-hearing workshop where we explain to people what the document says. And that way they might know what they are commenting on. Perhaps the hour right before the hearing so people understand what to comment on.

Dr. Turner: That's an absolutely great idea.

#### **4.4 Reports by members of the Board on their activities on behalf of the Board.**

Dr. Turner: I talked to Supervisor Jake McGoldrick about Proposition 63. It was a very useful meeting.

Ms. Walker: Kevin and I went to see Supervisor Sean Elsbernd. He's concerned that the mental health money will be going to housing.

Mr. Hines: And specifically he wants it to be going to the younger generation, help them get stabilized. He was worried it would go to older homeless and not enough to youth who are in need.

#### **4.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.**

Ms. Lebish: In the wake of our federal government's dilatory and ignominious response to Hurricane Katrina, I would like to suggest conducting due diligence, that we have a mental health emergency response plan, so we don't have things like people jumping off the Superdome, and so people can get their medications.

#### **4.6 Public comment relevant to Item 4.0**

No public comments.

#### **5.0 PUBLIC COMMENT**

No public comments.

#### **6.0 ADJOURNMENT**

There being no further business, the meeting was adjourned at 8:44 p.m.



**SAN FRANCISCO MENTAL HEALTH BOARD**



Gavin Newsom  
Mayor

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**MEETING OF THE MENTAL HEALTH BOARD**

Wednesday, October 12, 2005  
1380 Howard Street  
5th Floor, Room 537  
6:30 p.m.

**PLEASE NOTE: THIS MEETING IS BEING HELD AT 1380 HOWARD**

**AGENDA**

DOCUMENTS DEPT.

**CALL TO ORDER**

OCT 11 2005

**ROLL CALL**

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**AGENDA CHANGES**

10-11-05A10:54 RCLVD

**Item 1.0 DIRECTORS REPORT**

For discussion.

1.1 Dr. Robert Cabaj, Director, Community Behavioral Health Services  
A report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

1.2 Public comment relevant to Item 1.0

**Item 2.0 PRESENTATION - Alecia Hopper and Antonio Morgan, Mental Health Association, Overview of the Mental Health Services Act Draft Plan**

For discussion.

2.1 Alecia Hopper and Antonio Morgan, Mental Health Association, Overview of the Mental Health Services Act Draft Plan

2.2 Discussion of possible future actions related to presentations

2.3 Public comment relevant to Item 2.0

**Item 3.0 ACTION ITEMS**

For discussion and possible action.

3.1 Public comment relevant to Item 3.0

### 3.2 Consent Calendar:

3.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of September 14, 2005, be approved as submitted.

#### Item 4.0 REPORTS

For discussion and possible action..

- 4.1 Report from the Executive Director of the Mental Health Board
- 4.2 Report of the Chair of the Board and the Executive Committee, including a report on the status of Proposition 63 planning and hearings to be held by the Mental Health Board. Discussion regarding the Board member roles in the upcoming hearings.
- 4.3 Report by members of the Board on their activities on behalf of the Board.
- 4.4 New business - Suggestions for future agenda items to be referred to the Executive Committee.
- 4.5 Public comment relevant to Item 4.0

#### Item 5.0 PUBLIC COMMENT

Members of the public may address the Mental Health Board on any items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board.

### ADJOURNMENT

#### DISABILITY ACCESS

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD). Five days notice before the meeting will help to ensure the presence of an ASL interpreter or sound enhancement system. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.
2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and 14 Mission. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.
3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley which runs on the opposite side of the building from 10th Street.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

#### **POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES**

The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

#### **KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE**

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Frank Darby  
Sunshine Ordinance Task Force  
City Hall, Room 244  
1 Dr. Carlton B. Goodlett Place  
San Francisco, CA 94102-4689  
Telephone: (415)554-7724  
Fax: 4(15) 554-5163  
E-mail: [sotf@sfgov.org](mailto:sotf@sfgov.org)

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from Ms. Hall, or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: [www.sfgov.org/sunshine.htm](http://www.sfgov.org/sunshine.htm)

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: [www.sfgov.org/mental\\_health](http://www.sfgov.org/mental_health). You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

#### **Lobbyist Registration and Reporting Requirements**

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site [www.sfgov.org/ethics](http://www.sfgov.org/ethics).



## Executive Summary

### Overview

In November 2004 the voters of California passed Proposition 63, the Mental Health Services Act (MHSA). The MHSA imposes a 1% tax on incomes in excess of \$1,000,000 dollars. Funds collected under the MHSA are to be used to fundamentally change access to, and delivery of mental health services throughout California.

Under the MHSA, each County will receive a percentage of available funds based on a complex formula developed by the State Department of Mental Health. According to the goals of the initiative, funds are to be used for the transformation of each County's mental health system into one that is consumer and family driven, recovery oriented, guided by best practices, and informed by outcomes.

The MHSA funds available to Counties in the first phase of MHSA implementation are those for Community Services and Supports. In order to be eligible to receive these funds, each County must submit an initial three-year plan developed through an open and inclusive community planning process that specifies how funds will be used to achieve the goals of the MHSA. The executive summary provides a brief overview of the planning process and the resulting plan.

It is important to note before describing San Francisco's planning process and the outcomes of that process, that the citizens of San Francisco broadly supported Proposition 63 with approximately 74% of voters supporting the measure in November 2004. Early media estimates projected that San Francisco would receive \$50 million or more in funding based on the high rates of mental illness and homelessness in the City. The community embraced the opportunity to participate in the extensive planning process as evidenced by the universally high number of community members participating in all planning activities.

Midway through the planning process, San Francisco's actual allocation of MHSA funds was determined to be significantly below early projections, at \$5.3 million for client services. While there was consensus that this funding was grossly inadequate to meet the City's multiple needs, the planning process continued with the goals of initiating services to address the most urgently needed priorities and documenting the remaining need to support unfunded priorities. In addition, the remarkable level of community participation in the planning process will continue to influence provision of behavioral health services throughout the City system.

### Where We Are Going

*It is our vision that all members of our community, young and old, who experience behavioral health challenges should lead happy, productive, and fulfilling lives, free of stigma, in a safe and least restrictive environment, and receive relevant and effective services from a comprehensive Behavioral Health System that is recovery-oriented and culturally-competent.*

- Vision Statement, The San Francisco Behavioral Health Innovations Task Force 2005

The San Francisco Department of Public Health (DPH) has been engaged with the San Francisco community in a process to achieve the goals of the California Mental Health Services Act (MHSA) and the President's New Freedom Commission Report. In March 2005, Mayor Gavin Newsom appointed Deputy Director of Health, Barbara A. Garcia to lead a 41-member, citywide taskforce in that effort.

The Behavioral Health Innovations Task Force (BHIFT) has developed an initial 3-year MHSA funding plan for submission to the State consistent with the Task Force's adopted Vision, Goals, and Guiding Principles, and the requirements of the MHSA. This document summarizes the 3-year plan and reflects the process that the Behavioral Health Innovations Task Force, engaged in to develop the Plan. The 3-Year Plan was informed by: a) the community, particularly consumers, their families, and behavioral health practitioners, b) current behavioral health needs data, and c) evidence-based practices and policies. It should be noted that the 3-Year Plan is an application to the State for funding under the MHSA and that a comprehensive work plan is being written to operationalize the information submitted to the State. The plan also builds upon and coordinates with a DPH process in progress since 2003 to combine Mental Health and Substance Abuse services into an integrated system of Community Behavioral Health Services (CBHS). The CBHS integration process includes a vision echoed by the BHITF where all consumers can easily access care in a system where "any door is the right door". While the planning for the CBHS process preceded the MHSA plan development, the work done to create a welcoming and accessible system for all consumers including those with co-occurring disorders, provided a foundation for the MHSA plan. Implementation of MHSA services and the final CBHS integration process will coincide and be complementary.

Recovery, cultural and linguistic competence, consumer and family involvement, stigma reduction, and the elimination of disparities in mental health care are central to the plan and the identified priorities. Although true transformation will require an on-going commitment far beyond the first three years, San Francisco will begin this transformative process by prioritizing and addressing the most urgent needs. The following points developed by the BHITF (a-k) will serve as guiding lights as we move through the years toward our vision.

- a) All consumers will be appropriately served with culturally competent, consumer-centered, integrated services that serve to reduce placement in hospitals, jails, Youth Guidance Center, emergency shelters and the streets.
- b) Alternatives to the use of emergency shelters, Institutes for Mental Disease (IMDs), skilled nursing facilities, hospitals, jails, and the Youth Guidance Center (YGC) will be expanded, especially targeting those who are currently unserved and underserved.
- c) Consumers and their family members will work with service providers to create a plan for preventing relapse and recidivism at intake into hospitals, jail, shelters, YGC and other placements.
- d) The City and County will continually invest in training and education of consumers, families and service providers to reduce the stigma of mental illness and to foster the vision and values of an integrated behavioral health care system.

- e) The structure and composition of services and supports will be designed so that consumers and family members will have easy access in obtaining services and supports including prevention, intervention and crisis services.
- f) Funding will be leveraged across City and County Systems to ensure integrated services and to maximize resources for consumers and their families in obtaining and maintaining recovery and wellness.
- g) Prevention and early intervention services will be enhanced throughout the service delivery system to help minimize chronic and severe mental illness in all age groups.
- h) A 24-hour, 7-day a week drop in center staffed by peers and professionals will be developed to help to divert people from Psychiatric Emergency Services (PES), hospital, jail, and other restrictive settings.
- i) Vocational training and education will be recognized as a cornerstone of all treatment and services. Consumers and family members will have access to these services and supports, and consumers will receive vocational training and education and will be hired widely throughout CBHS and contracting agencies
- j) All services, supports and programs will be evaluated using both systems-level indicators and consumer-level quality-of-life indicators, producing both quantitative and qualitative data. These outcome evaluations will be accessible and easily understood by the community, and will derive from an integrated data system that will maintain consumer and family confidentiality.
- k) Outcomes will be measured and reported to ensure that consumers experience a higher quality of life and that stays in high-end facilities are minimized, that homelessness diminishes, and that recovery and wellness proliferate. These outcomes will be used to inform policy and resource allocation.

## **Identifying First Priorities**

### **1. Outreach and Engagement**

San Francisco has a proud tradition of engaging the community and including diverse groups in public policy decisions. The MHSA planning process paid tribute to that tradition and far surpassed previous levels of consumer outreach. The Behavioral Health Innovations Task Force held over 70 meetings between April and August of 2005 to ask consumers, their families, service providers, and other members of the community what is missing from mental health services in San Francisco, and what they would like to see changed. Outreach included flyers, Internet, email, and in-person engagement efforts (in English, Spanish and Cantonese) and took into account the distinctive culture of each of San Francisco's neighborhoods. Meetings were organized to maximize involvement from different communities, and to invite discussion on focused topics (unmet needs, cultural competency, wellness and recovery, integrated services, etc.). Task Force meeting locations rotated to make it convenient for members of communities throughout San Francisco to attend at least one meeting.

Information collected during the planning process, including position papers, provider surveys, results of peer-to-peer interviews, penetration analyses, transcripts and summaries of meetings, and usage analyses were submitted to the Task Force for consideration and incorporation into the final plan. Consumer and family member input was an integral part of all information gathering



activities including 25% consumer representation on the Task Force. In addition, the plan is available for public review and comment for 30 days, and all comments received will be incorporated into the final plan.

## **2. What We Learned**

Many issues emerged from the extended deep listening and learning process including the understanding that we have a long way to go before the vision of a truly transformed mental health system is realized. Specific issues that emerged were:

- While consumers in San Francisco are offered more recovery-based programming and active involvement in their own recovery than are consumers in other systems, many consumers and families still experience services as fragmented and hard to access.
- San Francisco's Sheriff's Department and Police Force are better informed about mental health needs than many other Counties
- San Francisco's direct service providers are diverse and often bilingual
- Top officials recognize the importance of the self-help movement
- Paralyzing stigma around mental health plagues the Asian and Latino communities
- More "least-restrictive" alternatives need to be available and used to divert African Americans and others from jails, juvenile hall and mental hospitals
- Services are not fully integrated for consumers with co-occurring disorders
- There are hundreds of consumers for whom services are not available in the language they speak
- Transitional Age Youth fall through the cracks when they age out of foster care
- Early intervention could be improved if there were more access to mental health services through primary care
- Homeless consumers have many needs that are not being met
- Very few consumers and families are full and active partners in their own recovery

In sum, we learned that San Francisco is in a perfect position to make dramatic changes to the way mental health services are experienced. The Behavioral Health system has strengths to draw upon, compelling need, and the Department of Public Health, the Mayor, and consumers and community members are aware of what needs to change, and are willing to commit their time to enacting those changes.

## **3. Priorities Chosen for Each Age Group**

In response to MHSA funding requirements, discussions were organized by four different age categories, and sequentially ordered priorities from the deep listening and learning process are listed according to these categories: Children Youth and Families, Transitional Age Youth (16-25), Adults (18-59), and Older Adults (60 and older).<sup>1</sup> While many issues surfaced for each age cohort,

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<sup>1</sup> The detailed results of the prioritization process are attached to the plan as Appendix 6, which includes tables for each age group as well as service provider survey reports.

the amount of money available through the Mental Health Services Act is limited, so the long lists had to be reduced to include just the top priorities for each age group. These shorter lists were determined through voting and are shown in the box below. They are a small fraction of the needs identified through the consensus process over many months, but they represent the beginning points identified by the task force and community.

Children/Youth	Transitional Age Youth	Adults	Older Adults
1. Trauma resulting from witnessing of or being a victim of violence	1. Homelessness	1. Homelessness	1. Isolation
2. Juvenile Justice/Child Welfare system involvement	2. Youth aging out of the Child Welfare System	2. Incarceration	2. Hospitalization
3. Homelessness	3. Juvenile Justice System involvement	3. Hospitalization	3. Homelessness
4. Mental illness co-occurring with autism	4. Suicide	4. Suicide	4. Dementia
5. Undocumented	5. Lack of employment and inability to work	5. Inability to work	5. Suicide
6. Suicide	6. Trauma resulting from witnessing of or being a victim of violence	6. Trauma resulting from witnessing of or being a victim of violence	
	7. First break prevention management		

### First Steps Toward the Vision

Beginning to address all of the age-specific issues that came out of the planning process will involve two different approaches, in compliance with MHSA requirements. The first strategy is to maximize the number of consumers from each age group entering into full service partnerships, focusing especially on populations at risk for the priority issues. The second strategy is to improve the systems that serve people at risk for the priority issues, so that these systems are more recovery-based, accessible and consumer-centered.

#### 1. Full-Service Partnerships

In accordance with MHSA specifications, San Francisco will use the majority (51%) of Community Services and Support (CSS) funding for Full Service Partnerships. In short, Full Service Partnerships means that consumers become true partners in their recovery plans, and it means doing "whatever it takes" to make an impact on people's lives in terms of housing, relationships, resources during crisis, education and employment, and fewer involuntary services. Each individual identified as part of the initial full service population will be offered a partnership with the county mental health program to develop an individualized services and supports plan, based upon principles of recovery and wellness.

Given the limited funding, estimated 5.3 million for services, and the priorities that emerged from the planning process, a total of **122-153** individuals and families per year will be part of the initial full service population for these first three-years, as follows:

**Children Youth and Families:** In the first three years, we will fully serve **27-34** children, youth and families, focusing on children and youth who have been exposed to violence, in Child Protective Services, in Foster Care, in the Juvenile Justice system, and those who are homeless.

**Transitional Age Youth:** Full service partnerships will be offered to **34-43** transitional age youth between the ages of 16 and 25. We will focus on youth who have been exposed to violence, who are homeless, who have aged out of foster care, who are immigrants, and those who are immigrants.

**Adults:** Between **27** and **34** adults will be served in full service partnerships, with an emphasis on homeless and Veteran adults, women with children, victims of violence, adults in jail, and adults who appear to be inappropriately served by the system as evidenced by a "revolving door" of relapse.

**Older Adults:** In providing full service partnerships to **34-43** older adults and seniors, we will target those who are hospitalized in high levels of care, those in Adult Protective Services, the homeless, monolingual older adults, and those who are particularly isolated.

## **2. System Development**

By way of addressing the identified priorities for individuals beyond the 153 who can be served with full service partnerships, San Francisco will use the remaining 49% of CSS funding for systems development. The Mental Health side of CBHS currently serves over 2300 unique consumers each year with an additional 11,280 individuals receiving treatment from the substance abuse side. Funds will be used to improve programs, services and supports for the identified initial full service populations. General system development funds will help to improve programs, services and supports for all clients and families (including but not limited to initial Full Service Partnership populations) to change service delivery systems. These efforts will include strategies for reducing ethnic disparities and for outreach and engagement of populations that are currently receiving little or no service. Eliminating ethnic disparities and reaching people who are currently unserved and underserved is a primary focus of this plan and of San Francisco's transformation in mental health.

Again by age category, the system development funds will be specifically dispensed in the following ways:

### **Children Youth and Families:**

- ❖ \$120,000 will be used to serve 100 children and youth each year for three years in community-based violence and trauma recovery services, including a peer-support component for youth.
- ❖ \$120,000 will be used in integrating psychiatric services within pediatric settings for early identification of mental health and psychiatric needs.
- ❖ \$121,490 will be used to increase organizational and clinical capacity to specifically serve Lesbian, Gay, Bisexual, and Transgender, Asian/Pacific Island, indigenous, Latino and African American children and youth with culturally appropriate services.
- ❖ \$80,000 will be used in school-based services including wellness centers.

### Transitional Age Youth:

- ❖ \$152,835 will be used to integrate behavioral health services within primary care settings that serve transitional age youth.
- ❖ \$200,000 will be used to provide supported services for housing, including co-op housing, independent living and board and care.
- ❖ \$300,000 will be used to do outreach and engagement and to support youth-run and youth-developed services using the Youth Development Model.

### Adults:

- ❖ \$131,490 will be used for supportive services for housing, including peer case management.
- ❖ \$100,000 will be used for Vocational Rehabilitation. Through a partnership with the Department of Rehabilitation, this funding will expand to \$400,000, as they will match \$3 for each \$1 of CSS money spent.
- ❖ \$130,000 will be used to support a peer-run center that will include crisis drop-in and a 24-7 warm line.
- ❖ \$80,000 will go to residential treatment.

### Older Adult:

- ❖ \$180,000 will be used to support a senior recovery center that offers peer support and outreach.
- ❖ \$300,000 will be used to provide supportive services for housing including peer case management.
- ❖ \$172,835 will be used for mental health services in primary care settings, including dementia behavior management.

The table below provides a snapshot of funding for Full Service Partnerships and System Development activities as they apply to some specific target populations and service categories. This table was developed using the following assumptions: 25% of all people served in FSP and through System Development will be homeless, 25% of all people served in FSP and through System Development will be victims of or exposed to violence, 15% of new staff hired to administer FSPs will be peers or family members.

Service Activity/Target Population	FSP	System Dev	Total
Housing Services	\$574,388 (25%)	\$711,490	\$1,285,878 (29%)
Violence related services	\$574,388 (25%)	\$641,363	\$1,215,750 (27%)
Peer run services	\$344,633 (15%)	\$831,490	\$1,176,123 (26%)
Services at Primary Care		\$445,670 (10%)	\$ 445,670 (10%)

## **Measuring Progress**

All of this money will be meaningless if actual changes do not result from the efforts we implement. We plan to learn from evaluations and make sure that the programs make a measurable difference in the lives of the people they serve. Below are the ways we plan to measure progress in transforming the mental health system.

### **1. Full Service Partnerships Goals**

We anticipate measurable change to result from the efforts outlined in the MHS&A plan for the first three years. We also expect, as the process continues beyond year three, that momentum will increase, and that the changes will continue and grow. The following goals will be met with the 153 individuals in Full Service Partnerships (FSP) during the three-year plan; similar impacts will be measured among more Full Service Partnerships in subsequent years.

- There will be a reduction in the use of jail, juvenile detention, and mental hospitals for individuals in FSP.
- Clients will demonstrate improvements in quality-of-life measures such as:
  - Safe and adequate housing
  - Meaningful use of time, such as increased employment, vocational training, education and social and community activities
  - Supportive relationships
  - Timely access to needed help, including times of crisis
  - Reduction in incarceration, hospitalization, involuntary services and out of home placements.
- Vocational training and self-help will result in greater autonomy and employment for FSP clients.
- Clients with co-occurring disorders will experience more appropriate recovery assistance and will report improvements on all fronts.
- Clients will receive services that are culturally competent and in the language they are most comfortable speaking.

### **2. Systems Development**

With the 49% of funds that go toward Systems Development, we expect to accomplish the following:

- ✓ Integrate consumer and family member involvement at every level of the organization including governance and service delivery – as volunteers and staff (professional and para-professionals).
  - Consumers and family members will be supported and provided assistance to serve on all Boards of Directors and Advisory Boards, and organizations will be encouraged and assisted to build consumer and family member involvement on their Boards of Directors and Advisory Boards.

- ☐ Consumers and family members will receive education and training on working with Boards, advisory boards, and within CBHS.
- ☐ Employment opportunities for consumers will be created and supported.
- ☐ Staff and volunteers will receive education and training to work with consumers and family members as full partners.
- ✓ Provide services that are non-stigmatizing and are community-based, ideally located where people naturally go, such as schools, health clinics, and community organizations.
- ✓ Ensure that decisions regarding individual care and services are made with the consumers, and family members when appropriate.
- ✓ Ensure that for children, decisions regarding individual care and services are made by and with the family or the identified responsible parties.
- ✓ Ensure that family members are heard in planning and service delivery.
- ✓ Provide services that build on strengths of consumers of all ages.
  - ☐ Service providers (medical staff, case managers, and so on) receive training and education on how to communicate most effectively with family members, while following confidentiality laws.
  - ☐ Family members receive training and education about mental illness and effective advocacy for family members
- ✓ Provide prevention and early intervention services, that will help divert people from hospitals, jails, homelessness and the Youth Guidance Center.
- ✓ Provide culturally competent education, which includes youth culture, to all service providers at all levels of care to reduce the stigma of mental illness.
- ✓ Provide culturally competent and linguistically appropriate services.
- ✓ Provide services that foster wellness and recovery and are evidence-based practices.
- ✓ Ensure that consumers receive fully integrated health care services – mental health, substance abuse and primary care – that work collaboratively with other systems such as social services and justice systems so that care plans and treatment are coordinated.

## **The Long Road to Fulfilling the Vision**

### **1. How \$10 Million Transforms \$200 Million**

The MHSA money amounts to a total of \$10 million, which is very little considering the mental health needs of San Francisco. Clearly, the MHSA funding will not be enough to truly transform the system all by itself, but the MHSA plan will set the process of transformation in motion. In other words, these plans for full service partnerships and system development will act as a catalyst for the larger mental health care system of San Francisco, which has a total budget of \$200 million and has an impact on thousands each year. The planning process itself has involved outreach to the consumer and family community in an unprecedented way, engaging consumers who have never been involved in consumer-advocacy groups in actual policy decisions. The long lists of priorities that the listening and learning process revealed will continue to shape decision-making, and future oversight will always involve consumer participation. The recovery and self-help



movements have touched San Francisco in an irreversible way that will impact future spending decisions.

## **2. Building on Strengths to Change the Culture of Mental Health Services**

San Francisco is primed for a different approach to mental health, one that builds on the budding achievements already accomplished here. In San Francisco, there are currently providers who embrace recovery, wellness and resiliency models for mental health. The planning process revealed that there is growth that must take place in this approach system-wide, but the work that has already been done sets the stage for this three-year plan to yield successful outcomes. Similarly, building cultural and linguistic capacity, employing least-restrictive approaches, applying early detection and intervention strategies, and making sure that practices are outcome-driven are all valued by San Francisco. But these concepts have not been the *driving* force behind funding and programming decisions, until now. The Full Service Partnerships and the system development plans outlined in this plan are San Francisco's first steps toward a very different, consumer-centered approach to mental health. These steps will be measured carefully to monitor how successful these efforts are in changing people's lives.

### **The Plan**

#### **1. Why this Plan Was Written**

The MHSA CSS plan for the City and County of San Francisco was written in response to California's Proposition 63, passed by voters in November 2004. The initiative is meant to provide funding for community-based mental health services and supports in every county in the State. San Francisco prepared this three-year plan, and submits it to the public for review before submitting it to the State. It will be reviewed annually, in accordance with the requirements of the Mental Health Service Act. The structure of the plan was determined by the California Department of Mental Health, and the content came from the extended community planning process that began in February 2005 that continues to give guidance.

#### **2. How to Read the Plan**

With the exception of the Executive Summary, the plan was written in strict accordance with the structure delineated by the Mental Health Services Act. Headings and subheadings in the 120+ page document are all derived from questions the state required to be answered in the plan. The plan is divided into two Parts and several subsections, and is followed by several appendixes and attachments. Below is a brief guide to the lengthy plan.

- a) Part I: Provides a detailed account of how community outreach was conducted to ensure consumer and family participation in the planning process.
- b) Part II Section I: Discussed the priorities that were identified for each MHSA-designated age cohort and why they are prioritized.
- c) Part II Section II: Describes the unserved and underserved populations in San Francisco and discusses ethnic and cultural disparities, using county data.
- d) Part II Section III: Discusses Full Service Partnerships populations and how and why they were selected.
- e) Part II Section IV: Discusses the proposed MHSA-funded programs and strategies.



f) Part II Section V: Discusses the strengths and limitations of the current system's cultural and linguistic capacity.

g) Part III: Required Exhibits

h) Appendixes and Attachments: Notes from planning meetings, other state forms and tables that clarify the planning process are attached at the end of the plan.



# SAN FRANCISCO MENTAL HEALTH BOARD



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## UNADOPTED MINUTES

### Mental Health Board

Wednesday, October 12, 2005  
1380 Howard Street, Room 537  
San Francisco, CA 94103  
6:30 p.m.

## DOCUMENTS DEPT.

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**BOARD MEMBERS PRESENT:** Rebecca Turner, Ph.D. (Chair); Benito Casados; John Kevin Hines; LaVaughn Kellum-King; James Shaye Keys; Claudia Lebish; James L. McGhee; Toye Moses, Ph.D., M.P.H.; Tom Purvis; Jagruti Shukla, M.D., M.P.H.; Kate Walker; Idell Wilson.

**BOARD MEMBERS ABSENT:** Bob Douglas, J.D.; Supervisor Bevan Dufty; Michael Medema; Dorothy Shaffer, R.N., N.P., M.S.N.; Lisa Williams.

### PRESENTERS:

Alecia Hopper and Antonio Morgan, Mental Health Association of San Francisco

**OTHERS PRESENT:** Robert Cabaj, M.D. (Director, Community Behavioral Health Services); Mike Wise; Emeric Kalman; Philip Rambo; Helynna Brooke (MHB Executive Director); Rich Snowden (MHB Administrator).

### CALL TO ORDER

The meeting was called to order at 6:35 p.m. by Rebecca Turner, Chair.

### ROLL CALL

The roll was called.

### AGENDA CHANGES

No changes.

## 1.0 DIRECTORS REPORT

### 1.1. Report from the Director of Community Behavioral Health Services

Dr. Cabaj: The biggest news is still the Proposition 63 Draft Plan. The executive summary was posted over a week ago. We're working on a three-page summary for the Health Commission. But the 11-page executive summary is very good.

The next step is that the Mental Health Board will hold hearings.

The timeliness of submission is important. Right now we can easily get six months of funding, but they won't release the funds for the clinical services until the plan is accepted by the State, and it takes three months for the State to process and approve the plan.

The soonest we can get it to them is November 1st and that means the soonest we could get the money would be February 1st. It's urgent to get the plan to the State as soon as possible.

We're continuing the integration of substance abuse services and mental health services. We had a very good meeting with Zialogic, our consultants.

The "welcoming" focus, which is a key part of integration, does not mean a party, but welcoming everyone in who comes for services, and that people are made to feel part of our system no matter what their situation. We want a universal screening form so we will know all the issues they need help with. We're going to have a focus on maximizing revenue and making sure that we are getting reimbursed from all the funding streams possible. We want to make sure that the system is dual diagnosis capable.

Regarding the CalOMS issue, it sounds like more paperwork, but it's a good thing, because it will give us measures of progress and outcomes and it will be standardized across the state, so we will be able to do comparisons. It will all be computerized.

Ms. Brooke: With regard to Project Homeless Connect, a concern that's come up is that there are not enough support services. What kind of follow up are they doing?

Dr. Cabaj: We're working on setting up temporary intensive case managers, and hopefully then we'll be able to bring people into the system. We've had some pretty good follow through. For example, with the methadone program, we have a 50% follow through rate which is good for that service.

Mr. Keys: Project Homeless Connect for one day sounds absolutely fantastic, but when I walk the streets of San Francisco day by day, I see lots of people camping out. I know there is a team through the Department of Public Health, and their response is a one-time shot and there is no follow up. When I call them through Supervisor Daly's office, that's what happens.

Dr. Cabaj: This is again about not having enough staffing. The AB 2034 outreach program is limited to 129 clients. There is also the Homeless Outreach Team. I've donated most of the staff to that team. It's an amalgam from DPH and DHS. But we only have enough staff for this one team. The team is targeting the Tenderloin first, and they hope to go into other neighborhoods. We haven't been able to get any new money for outreach at all, so we have to piece it together from other services. The reason Project Connect is so exciting is because it brings in thousands of volunteers.

Mr. Keys: You have a wealth of knowledge in terms of people who have been through the system who could help others.

Dr. Cabaj: Yes, through Prop 63, we're focusing on peers, and peer-run services. Some of the members of the Homeless Outreach team and the AB 2034 team are formerly homeless people themselves.

Mr. Casados: I want to talk about the billing process. I understand you are re-doing the billing process. Is there going to be a better way for people to get answers to their questions? I work the front desk at 1380 Howard, and I get a lot of calls about billing. I give them the number, but no one returns those billing calls. There are staff who don't want to be bothered with it. When you re-write these billing processes are you going to be able to coordinate that into being able to answer questions for the clients who don't understand when you send them a bill?

Dr. Cabaj: We want to look at this as if we were a private business, and we would lose clients if we didn't treat them well. The billing office has been very understaffed. They have lost two people there. Prop 63 will add one more person. Also please let me know if someone in particular is treating people disrespectfully.

Mr. Casados: People have told me they have been waiting six days for a return call from the billing office.

Dr. Moses: I want to follow up on what James Keys said. Project Homeless Connect is a good thing. I think it is important that we let people know that the Mental Health Board is involved in the issue of homelessness. When you are listed on something having to do with homelessness, also mention you are a member of the Mental Health Board.

Dr. Turner: Are people from the Department going to be attending our hearing? And how will the information be used by the Department? Will someone from the Department be there at the beginning of the hearing to give an overview of the plan?

Dr. Cabaj: I plan to be there, along with Edwin and Carolyn. I think Barbara Garcia will be able to be at both hearings. In terms of the information, the consultants from RDA will also be there. They will be taking in the information and then will be looking at what we need to comment on or changes we need to make in the plan or explain why we are not making certain changes in the plan. We believe we can incorporate changes and be able send off the plan by November 1st.

Carol Hood from the State Department of Mental Health said today that the MHB does not have to sign off on the plan, that once it is amended it can be sent to the State.

Ms. Brooke: So you see our final role being the hearing on the 24th, but not making recommendations?

Dr. Cabaj: Yes.

Dr. Turner: We may want to have a meeting on October 26th.

Ms. Brooke: If we're not going to be meeting separately, then each Board member may want to say something during the hearing process.

Dr. Turner: That's what I was thinking. We'll make a decision about this as a Board.

Mr. Casados: Are the explanations going to be made available to the public?

Dr. Cabaj: Yes

Dr. Turner: One of the things we talked about in the Task Force is Mobile Crisis. We considered that a high priority. Is Mobile Crisis included in the plan?

Dr. Cabaj: They took out the "mobile" and wrote up that section as crisis services in order to give more flexibility. Mobile Crisis will be included in the \$130,000 for the crisis center and warm line. We wanted to have a wider net than just Mobile Crisis.

Dr. Turner: I notice there's not very much being made of these hearings by the City. There's no press conference by the mayor. I'm a little bit surprised. It feels rather anti-climatic. So I'm wondering about that.

I'm very excited to see the executive summary. The Mental Health Board was from early on very concerned about having a user-friendly executive summary.

Dr. Cabaj: The dream was to have the executive summary released on the same day as the plan. The first summary was way too technical, and the second one was way too "folksy." So then Carolyn Lieber headed up the writing of the executive summary. We wanted to capture the spirit and the bigger vision of transforming the system. We're working to get it translated into Spanish, Chinese, Vietnamese and Russian.

In terms of the press conference, maybe you should call the Mayor.

Ms. Brooke: I have called and called.

Dr. Cabaj: In LA there's an article every week about their plan. Other counties have been getting press. I had a talk with some press people at the meeting of the Neighborhood Services Committee of the Board of Supervisors, but I did not see any follow up in the media.

Dr. Turner: I'll call the Mayor's Office again. I've never seen something so perfectly addressed to the mayor's concerns and the concerns of Sophie Maxwell and Bevan Dufty. I cannot imagine not using this as an opportunity for public awareness.

Jo Robinson has made us aware of something that is inaccurate in the plan regarding the number of people needing jail psych services. The figures in the plan are a significant underestimate.

Dr. Cabaj: I thought the RDA consultants had made the changes in the data that she submitted. Since this is still the draft plan we can make that change in the adopted plan which we will submit to the State.

Mr. Purvis: The executive summary is not required by the State, but will we submit it to them?

Dr. Cabaj: Yes, we will do that, because people at the State will probably not read through the entire plan.

Mr. Keys: You have supportive services for housing. I'm a huge advocate for people getting their own housing. I want to see people not just in an SRO, but in something nicer, with a bathroom and economic kitchen space.

Dr. Cabaj: Because they gave us such limited funding, we can only provide clinic services. It won't allow us to provide funding for creating new housing. But there are still several pots of money, including capital funding, which we might be able to use for creating new housing, or supporting a housing bond.

Mr. Keys: The homeless population in Los Angeles is due largely to a lack of jobs. Homelessness in San Francisco comes more from drug abuse and mental health issues. I heard that the State did not count the homeless. Will you send that concern along with the report?

Dr. Cabaj: The State has definitely heard from us about that. The State said there was no accurate count of the homeless. The state mental health directors were very upset about that, because we had all done a count on the same day and felt we had very good data. The State also said, the money was only for mental health and not to serve substance abuse issues. But we are a behavioral health agency and 41 other counties are behavioral health, too, so they are considering that.

Dr. Shukla: Since there may be additional money from the State, is there an opportunity for the Board to comment on what the priorities should be if additional money is available?

Dr. Cabaj: There is still the set aside money of \$35 million. We've met with the State. We estimate that we could apply for \$20 million of that. We figure it's about \$20,000 per person per year for a full service partnership. So \$20 million would let us treat another 1,000 clients. There may be unspent money from counties who don't apply for all their money or use all their money. I have also been working with the oversight commission. They may be wanting to revisit the allocation formula within a year rather than three years from now.

The written Director's Report was distributed:

**SF Prop 63 Plan.** The San Francisco 3-year Program and Expenditure Plan for Community Services and Supports (CSS) under the Mental Health Services Act (MHSA) has been released by DPH/CBHS for 30-days of public review in preparation for hearings to be held by the Mental Health Board (MHB) to receive comments on the proposed Plan. The MHB hearings will be held on the following two dates:

**Saturday, October 22, 1 - 4 PM,** at Joseph Lee Recreation Center, 1395 Mendell  
**Monday, October 24, 4 - 7 PM,** at Board of Supervisors Chambers, City Hall, 2nd Floor



All are encouraged to attend, and provide comment, at these hearings.

DPH/CBHS staff, with assistance from Resource Development Associates, developed the 3-year Plan, which will be submitted to California Department of Mental Health to access \$5.3 million per year in CSS funding for San Francisco. The proposed Plan is based on the priorities and strategies identified by the extensive community planning process led by the San Francisco Behavioral Health Innovations Task Force. The 3-year Plan is available for review online at:  
<http://www.sfdph.org/Prop63/drg/Prop63/default.htm>

**Integration Policy Priorities Set for 05-06.** In two days of meetings in September, facilitated by ZiaLogic integration consultants, members of CBHS central administration, Integration Advisory Committee, and Change Agents, identified four priorities for system policy development in 05-06 to further the integration of mental health and substance abuse services in CBHS, as follows:

- a system-wide Welcoming Policy
- a policy on Universal Screening for Co-Occurring Disorders
- a Billing Policy that provides a set of instructions for the appropriate use and billing of Medi-Cal towards the treatment and care of co-occurring disorders, and
- a useful definition of Dual Diagnosis Capability to guide program approach and implementation

Work will soon begin on developing the above policies. Participation and feedback will be sought from clients, family members, and providers. For more information on how to get involved, please contact your CBHS Program Manager.

**CalOMS in place.** The new CalOMS (Outcomes Measurement System) data-entry screens have been loaded onto the CBHS InSyst Billing Information System, in preparation for the collection of outcomes information for substance abuse treatment clients, as required by the state Department of Alcohol and Drug Programs, starting January 1, 2006. Please stay tuned for announcements of trainings to be held in December on the use of these screens. New BIS Client Registration and Episode forms corresponding to the new BIS screens will be distributed in December. Please do not enter data into these new CalOMS screens until January 1, 2006. BIS Data Entry Users may simply press Return (enter) to bypass these new screens at this time. If you inadvertently enter the screens, you will need to tab through the fields to the end of the screens. Data fields are currently optional, with one exception, 'Date of Birth' - which has to be completed if you inadvertently enter the screens.

**Family Mosaic Project Open House.** The Family Mosaic Project (FMP) hosted a very successful Open House last October 6. The open house was a collaboration with other social service agencies in the building complex at 1305-1333 Evans St. The participating agencies included: Bayview Hunters Point Family Resource Center, Child Support Services Office, Infusion One, and CBHS Children's System-of-Care. Refreshments were served by all the programs, and raffles held as well. Mario Hernandez from CBHS donated his time to provide massages throughout the event. Occupational Therapy and Treatment Program provided activities for children, and PHN students provided blood pressure screening. Over 100 people, representing various agencies, attended and

circulated throughout the building. The district's Supervisor, Sophie Maxwell, dropped by, and 1380 Howard St. was well-represented by Sai-Ling Chan-Sew, Dr. Irene Sung, Phillip Tse, Terry Ryan, and myself. Charlie Morimoto, former program director of FMP, also attended. Representatives from HSA, Probation Department, Bayview Hunters Point Foundation, Edgewood, IFR, Rise, Southeast Children and Family Center, AARS, RAMS, JCYC, and Westside CMHC were there, along with other providers, consumers, and community members. It was a great time for all, and a wonderful opportunity for networking among agencies and community representatives.

**South of Market MH Clinic holds first staff awards.** South of Market Mental Health Center celebrated its 1st Annual Staff Appreciation BBQ Day on September 28. This event was developed to recognize and to celebrate the staff, as well as to support team building. The "Clinic Choice Awards" were presented to individual staff voted by their peers. Eccentric trophies, including for unusual award categories, were developed and constructed by the awards organizing committee. The 2005 winners, selected by the staff, included: Mabel Jung, Special Award for Leadership; Alex Barnes, Peacemaker Award; Lila Ko, Voice of Reason Award; Gary Johnson, Most Diligent Paperwork Award; Larry Bevan, Humanitarian Award; and Kenneth Lim, Beyond the Call of Duty Award.

#### Other Upcoming Events:

**PROJECT HOMELESS CONNECT VII** - The 7th Project Homeless Connect (PHC) outreach day will be held on Tuesday, October 18, 10 AM - 3 PM, at the Bill Graham Civic Auditorium. PHC is a bi-monthly event that provides homeless San Franciscans immediate access to health care, benefits, and other social services. Since October 2004, PHC has served 5,506 homeless individuals, housed and sheltered 383 people, provided medical care to 513 individuals, drug treatment to 402, legal assistance to 347, and county benefits to 638 people. To volunteer your help for PHC 7 on October 18, sign-up at <http://www.projecthomelessconnect.com/rsvp.html>. For more info, visit the PHC website at <http://www.projecthomelessconnect.com/>

## **2.1 PRESENTATION: Overview of the Mental Health Services Act (Proposition 63) Draft Plan**

Ms. Hopper: Thanks for inviting us here. The Proposition 63 Campaign Committee reviewed the Draft Plan, and tonight we want to tell you some of the things that have come up during that process:

First, the allocation. We were all extremely disappointed with how much San Francisco received under the allocation formula. It's pretty challenging to do a huge system transformation with a small allocation. But we've heard from Bob Cabaj and Barbara Garcia that there will be a transformation of the entire system. And we want to see that there is public comment about that at the Mental health board hearings. This is the first time in a long time we've been able to ask the public what they want in the mental health system.

Mr. Morgan: I think the plan represents the spirit of the Mental Health Services Act. I looked particularly at housing issues and vocational services. Some consumers get stipends, but we want consumers to have jobs.

Ms. Hopper: One recommendation we're making to our constituents is that we have the capacity and the need that is greater than the \$5 million allocation. We'd like to see additional language included showing the State what we would do with additional funding.

Bob was talking about southern California counties getting more money than San Francisco. But we have the kind of capacity to provide services that many southern California counties don't.

Mr. Morgan: The State is not recording and looking at the number of people who are coming from other counties into San Francisco to get services.

Ms. Hopper: Second, the language in the executive summary about the vision of the plan is really good. Thank you, Bob and Carolyn, for working on that. The Draft Plan is really hard to get through. We want to make sure that the executive summary is submitted with the plan and that all the language in the executive summary is incorporated in the plan.

Third, the data and the reflection of the unmet needs. I was concerned while reading through the plan that the data San Francisco used is the same data the State used. One of our concerns is that the prevalence data does not reflect reality. The State says there are 15,000 people needing treatment, but our system is already treating 23,000.

Dr. Cabaj: That's just mental health services. If you include substance abuse services, the number is 32,000.

Ms. Hopper: We think it is important that we use the unmet need data that reflects the reality of San Francisco. We know our need is greater than what the State is saying. The State has under-estimated what San Francisco's need is.

Mr. Morgan: This is the first step. This has never been done before. We're optimistic. We basically like how the plan was written. We hope we can get the full \$20 million allocation to do transformation of the system.

Ms. Hopper: We were asked to address three questions sent to us from the Mental Health Board.

First, whether or not this plan is responsive to the spirit of the proposition.

It is, as long as the language of the executive summary is included in the plan. But without that language, the Plan does not reflect the spirit.

Second, does the plan show an actual transformation of the system?

The allocation is \$5.3 million and we appreciate that, but how can you transform a system with \$5.3 million? We need to keep reminding the Department of Public Health as advocates what we are asking for in the transformation of the system. The principles established here can help guide the Department. This plan is only the first step.

Third, does the plan identify the unmet need in San Francisco. I don't think it does, but we don't have the systems in place to bring in accurate data.

Mr. Keys: Thank you Alecia. I appreciate you and Antonio coming here. I wanted to ask about the additional language you want to have in the executive summary to ask for future funds. Do you have anything written up? Do you have a plan all ready for that language? What we are going to do with it specifically?

Ms. Hopper: I think we do have that information, because that was the job of the Task Force to seek that information from the public. The Task Force has actually ranked areas that need funding. Only the top three are getting taking into account in the Draft Plan, so all the other priorities count as unmet needs.

Mr. Keys: What is our need?

Mr. Morgan: In the executive summary, it talks about consumers leading happy, productive, fulfilling lives. How does a fulfilling life happen on \$700 a month? What I like about the plan is that there is focus on housing. But I'm an advocate, too, for vocational training, because people need money to have a fulfilling life and make progress.

Mr. Keys: Perhaps some of the clients could work with other clients, and often do a better job than clinicians. Clients are able to talk to other clients, as opposed to someone with a degree who might make a client feel closed in or shut down. And you could save on salaries, too.

Dr. Cabaj: Everything you're saying is right, James. The Recovery Model does exactly that. I've been advocating for that for years. We adopted the Recovery Model in 2003 before the MHSA. This funding helps move us forward with that model.

Mr. Morgan: As a consumer, I found out through the Task Force that there are some clinicians who have the best interest of the clients at heart. Before being on the Task Force, I thought clinicians didn't. Recovery is a journey. I'll be taking schizophrenia medicine for the rest of my life.

Mr. McGhee: What made you feel they didn't have your best interests at heart?

Mr. Morgan: I had a payee. I thought they were cheating me out of my money. That's the schizophrenia. My thoughts were racing, and people had an attitude with me, and we weren't getting anything done. But then I got this job at the Mental Health Association.

Sophie Maxwell, said you should hear from the people first. I said, yes, that's what it's all about. Now I see that there are clinicians with my best interests at heart, and there are some people who don't get it.

Ms. Kellum-King: I want to comment about facilities where you have to leave at 8:30 in the morning and can't come back until 4 p.m. Where are people spending that time? I think the system needs to plan something for people to do during that time.

Mr. Morgan: I was at Hospitality House when I was homeless. We had to be out at 8 a.m. and then back standing line in the afternoon to get a bed at 4 p.m.

Ms. Kellum-King: That needs to be addressed with the extra revenue. Go where? Do what?

Ms. Hopper: I think you're talking about having meaningful things for people to do during the day.

Mr. Hines: They told us to figure it out. I went to school, but other kids did drugs. They don't make sure you're doing something productive. They just say goodbye. If you're not capable of setting up something productive, you're just out of luck. Some kids need someone to walk them through it, like take them to school, and set them up with a counselor.

Mr. Morgan: Like a peer counselor.

Ms. Kellum-King: They could hire a peer who could help walk you through it and that would be an effective way to do it. This is a clear need that can be spelled out.

Mr. Casados: I like the plan. Don't get me wrong. I spent three weeks reading through it cover to cover. I don't think it meets the spirit of the MHSA. It doesn't cover the spectrum. I thought the MHSA was also to reach the jail population. This plan does not even touch the jail population, people who are in the jails right now, so when they come out they are ready to integrate back into our system. Another thing I've learned working at the front desk at 1380 Howard is that we can't even accept a collect call from someone at the jail and get them hooked up to the system. That's wrong. When you have people trying to meet a need, but they don't get help in doing that, then that does not resonate with the spirit of the MHSA.

The MHSA was to meet the needs of those with the most need. I am a client representative and I have to look at the whole spectrum. The State is going against what the voters said. What the MHSA says is that we're supposed to reach the whole spectrum.

Ms. Kellum-King: Isn't it true that the Los Angeles county jail is the largest mental illness institution in the State? And we have so many people in our jails that need help.

Ms. Lebish: There was a very interesting article in the *Chronicle* about homeless alcoholics. A lot of them are 5150'd. There is also a welfare code 5170. San Francisco doesn't have the facility to do 5170s, and provide immediate substance abuse treatment.

I want to tie that in with Project Homeless Connect. Is that something that could evolve into people being 5170'd instead of 5150'd?

Dr. Cabaj: There are no 5170 facilities in the State of California anywhere, even though that is in the code. In the old days, there used to be a 6-month commitment. We had that when I was in Massachusetts. But no one wants a 6-month commitment. The 5170 idea was to address safety and support. But there are so many regulations for 5170 facilities, and they are so expensive that they are not happening. Sacramento tried it, but the facility folded because it couldn't meet the state regulations. Technically we can't use Proposition 63 funding for that.

Ms. Hopper: Prop 63 can't fund involuntary commitment.

Mr. McGhee: Was the 5170 code designed that way? Was it designed to be a failure? Sacramento tried it and failed. What were the requirements that were so difficult?

Dr. Cabaj: The State is known for writing complex regulations that are so complicated that you can't meet them. I don't know what was behind it, but it is a matter of bureaucracy getting in the way.

Mr. Keys: In the executive summary, there is \$130,000 for a peer-run center, crisis drop-in, and a 24/7 warm line. Do you have any drop-in centers right now?

Ms. Hopper: There is no drop-in center like this now.

Mr. Keys: This will be a new center then. Perhaps there could be new money from the Board of Supervisors. Perhaps it could be located in the 6th Street corridor. How about giving the place some teeth, like access to beds, access to therapists, and access to support services.

Ms. Hopper: During the RFP process, that level of detail will be determined. Another thing I want to urge the MHB to do is to be involved in the RFP process, so all those kinds of things get translated into services through the RFPs.

Ms. Wilson: As a consumer, I'm telling you I'm just now understanding bits and little bitty pieces of this Draft Plan. Who are the people who are understanding this and agreeing with this? Did they hold a meeting and explain it to people? This is supposed to be a consumer plan.

Ms. Hopper: When I was talking about the committee, I was talking about the Prop 63 Campaign Committee that worked hard to pass the Proposition and has kept on meeting since then to monitor implementation as a group of advocates.

We have a group of people who did a lot of public comment during the Task Force hearings. We're meeting with them tomorrow to work with them about their responses to the plan and their testimony for the MHB hearings.

Dr. Turner: People on the Task Force expressed a lot of concerns about how the Draft Plan was written, that it was hard to decipher and get through it. I really don't think we



have a good sense of how consumers are responding to this. I think this is the main reason for having the Mental Health Board hearings. I know Jo Robinson wrote an e-mail about the inaccurate data. But I haven't heard consumers responses yet.

Ms. Wilson: The word "happy," take that out.

Ms. Hopper: That came up in our meeting, too. What does that word mean? And happiness is different for different people. The State has come up with a definition of recovering that shows the spectrum. That recovery is not just one thing, or the same thing for everyone.

Dr. Shukla: You commented that this is just the first step, and that the prevalence data is not accurate. Looking at the section regarding measurements, I don't see a lot of specifics in the executive summary. I wonder if that represents the emphasis on getting prevalence data so the City can show the State the data that proves the need. In terms of modalities of measurements, I don't see specifics. I'm hoping that that is emphasized, collecting the data in the future.

Ms. Hopper: My concern is that I don't know that the data systems in the City are able to collect the data we need. The MHB has a hearing every year to make sure goals are being met. That's one way to monitor data collection.

Dr. Shukla: It would be important that we're not here a year from now saying we still have no data. It's important to be getting the data right away.

Mr. Purvis: Regarding including programs that are not in the plan but might be included if we get \$20 million, is that practical in a document that has to be submitted by November 1st? Is there something that could be put in quickly?

Ms. Hopper: They have that information and they have a team of consultants who could write it up.

Mr. Purvis: Maybe a brief summary could be included indicating what we could do.

Ms. Hopper: That was definitely requested from the Task Force, that we detail what would do with additional money.

Mr. Keys: What methods have you come up with to explain the executive summary to people. There are some people who may not understand. A lot of people understand things in different ways. I remember there was a time when I couldn't understand math. Has the Task Force come up with some way, even a puppet show, about what this about, so people can begin asking the questions they need to ask. What is your role in finding different methods in making this plan comprehensible.

Ms. Hopper: The Mental Health Association is an education and advocacy organization. We've been working to help our constituency. It's really the role of the Department of Public Health to make sure that this is understandable to the people of San Francisco.



We're a small nonprofit. We have a team of consumers we've been working with for the last four months about the public comment process and now the specific details of the plan. We have five peer leaders. Getting the information out to the general public is more the role of the City.

Dr. Turner: I'd agree with that, that it is the role of the City to make sure peer leaders are reaching out to other peers. I think the MHA is doing everything it can.

Mr. Casados: I think the City has figured they got the report out and that's all they have to do. I think they have sorely fallen down.

Dr. Turner: They did make a valiant effort in response to strong criticism. But it's not all the way there. I'm empathetic with Idell. It's still a challenging document to read through. It would help to have a verbal explanation. That's why we are asking for an overview in each of our hearings. And we should provide input on how we think the overview should be done to make it useful to people.

Ms. Kellum-King: Maybe we can make "study groups." We could have meetings with the consumers.

Mr. McGhee: I chair the education committee of the Board of Psychology for the State, and we do a lot of work to get information out to the state. Here, we're talking about simplifying the executive summary so people can understand it.

Sometimes you can get so protective you don't do your job. You're talking about a community that sorely needs help, and I think that it's our job as the MHB to help that community, simplifying this report so people can understand it.

## 2.2 Discussion of possible future items related to presentations.

Dr. Turner: Any future actions the Board wants to consider?

Ms. Wilson: We have two subcommittees. Could we give this to one of the committees to take it?

Mr. McGhee: You can also appoint an ad hoc committee to do what you're talking about doing.

Ms. Walker: I think that's a marvelous idea. Could we set a date to discuss the executive summary and how we disseminate it? Could we get Stakeholders Committee together? And then report back to next meeting.

Dr. Moses: I'm thinking we can refer this to Stakeholders, and ask them to make recommendations to the Board at our next meeting.

Mr. McGhee: If you're talking about trying to simplify the executive summary, don't you want to do that before the public hearings?

Dr. Turner: What can realistically happen between now and the 22nd? Also we need to remember that Proposition 63 planning and implementation is going to be continuing, and there is still reason to continue to reach out to consumers.

Ms. Walker: I agree. I don't see how Stakeholders can have something by the 22nd, but this is a 3-year plan. Let's get working on it now in terms of educating consumers.

Dr. Shukla: Given the short amount of time, I think we should focus our energy on where it's most deserved, if we are not able to translate this into a more user friendly document.

Ms. Kellum-King: We have a large city, and we are talking about cultural competence. And if a representative of the southeast community can't articulate this to her community, then we have failed. Let's be a Board and let's be together.

Ms. Lebish: What's the possibility of changing the format of the hearing if we want to have more contact with people? Could there be some one-on-one time so it would be less intimidating than talking to a 17-member board?

Ms. Brooke: During the development of plan at the subcommittee meetings, there was a lot of time for dialogue. If there are members of the public who have issues and concerns, you can ask people to talk with you at another time. We can't change the actual hearing process at this time.

Dr. Turner: I support you and anyone else on Board who wants more time to talk through the executive summary and if you want practice talking about it. We are seen as leaders on mental health in the community. I think it would be good to draw upon Antonio and the peer leaders they are training. I'd be glad to spend time talking with any Board member about the report.

Ms. Walker: I agree with LaVaughn, and think that you're right. But it's now the 12th of October and we only have ten days till the 22nd. The kind of work you are suggesting, I agree with, but I don't think we can do it in time. I'd rather we do a good job.

Mr. Casados: We were told by the director that he had condensed the executive summary to two pages. Would it be possible ask him for a copy of that and send that executive summary to everyone? My guess is that it is an outline, and I'd be willing to talk with people about the plan if you want to talk to me.

Mr. Keys: LaVaughn's comment raised a question for me. At these two hearings, how are our populations of Asian, Latino, hearing impaired people going to be able to participate?

Ms. Brooke: The executive summary is being translated into four languages. We will be having translators for Spanish and Chinese at the hearing. And we'll be having assisted listening devices.

Mr. Keys: My experience with translations, is that there are different dialects. There are many Asian languages. Are these translators competent enough to get the information across?

Mr. Casados: I can vouch for them. I have seen their translations and they are excellent. They have worked extensively through the cultural competency office doing translations.

Mr. Keys: That's reassuring.

### **2.3 Public comment relevant to Item 2.0**

Mr. Rambo: I go to a meeting at 111 Jones on the first Thursday of the month. Someone there said there is a possibility of a 24-hour phone line. There is a line for the elderly, but you're lucky if you get through one out of eleven times. Then we have a mayor who says he thinks its outrageous that \$15,000 a year is spent on medical treatment for prisoners. We need to keep as many drug treatment centers open as possible.

## **Item 3.0 ACTION ITEMS**

### **3.1 Public comment relevant to Item 3.0**

No public comment.

### **3.2 Consent Calendar**

**3.2.a RESOLUTION (MHB-2005-31):** Be it resolved that the minutes of the Mental Health Board meeting of September 14, 2005, be approved as submitted, with the correction of Claudia Lebish being present and James Keys being present. (Passed unanimously.)

## **4.0 MENTAL HEALTH BOARD COMMITTEES**

### **4.1 Report from the Executive Director of the Mental Health Board**

Our 15th Police Crisis Intervention Training is coming up October 24-27.

### **4.2 Report of the Chair of the Board and the Executive Committee**

Dr. Turner: At our hearings we will have alternating categories of speakers. First will be a consumer or family member, then a speaker from the category of other, then a consumer or family member, and so forth.

Mr. Casados: I would like us to acknowledge Carolyn Lieber because she wrote 80% of the executive summary for the Position 63 Draft Plan. I'd like to ask the Chair to write a letter of commendation to her.

Dr. Turner: That will be done.

### **4.4 Reports by members of the Board on their activities on behalf of the Board.**

No report.

#### **4.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.**

Ms. Wilson: Since Prop 63 is ongoing for next three years, we need to put together a specific team on Prop 63. I think it's crucial for this Board to take more of a part in Prop 63 than what we have been given.

Mr. Hines: Could we talk about implementing serious suicide prevention classes in grammar schools and high schools? Suicide in San Francisco is higher than homicide almost by double. Suicide is higher than homicide almost by double across America. It's the third highest cause of death in youth.

Dr. Moses: Could we invite Margaret Brodtkin as well as Bill Sifferman, the new Director of the Youth Guidance Center to share their visions with us?

Ms. Lebish: I'd like to reiterate my request from the last Board meeting, to look at mental health care if a disaster hits San Francisco.

Mr. Keys: My pet projects are families and children in SRO's, outreach to the homeless on the streets, and prevention for children. Also outreach in schools to help children cope with issue of growing up, and to give them a better chance at whatever they are going to do in life. Maybe we could even invite our respective Board of Supervisor members to come sit in on our meetings and talk with us.

Mr. Hines: We could invite the kids from Youth Funding Youth. They give grants to kids under 18 who are doing socially relevant projects. These kids are awesome and they are working hard.

#### **4.6 Public comment relevant to Item 4.0**

No public comments.

#### **5.0 PUBLIC COMMENT**

Mr. Kalman: The Mayor has his Disability Council which has meetings. The MHB should also be represented on the Disability Council because mental illness is a disability

#### **6.0 ADJOURNMENT**

There being no further business, the meeting was adjourned at 8:34 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

Gavin Newsom  
Mayor

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**PUBLIC HEARING**  
on San Francisco's Draft Plan for  
**PROPOSITION 63**  
**THE MENTAL HEALTH SERVICES ACT**

The Mental Health Board will be holding two hearings on the Draft Plan for how San Francisco will use its Proposition 63 funding:

Saturday, October 22, 2005, from 1 p.m. to 4 p.m.  
Joseph Lee Recreation Center  
1395 Mendell @ Oakdale, 1/2 block from 3rd Street

DOCUMENTS DEPT.

OCT 11 2005

Monday, October 24, 2005, from 4 p.m. to 7 p.m.  
Board of Supervisors Chambers  
City Hall, 2nd Floor  
1 Dr. Carleton Goodlett Place  
Civic Center

SAN FRANCISCO  
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10-11-05A10:51 RCV

The Draft Plan is over 200 pages long, so we urge you to review a copy as soon as possible so you will have time to read through it and make recommendations.

There is also an Executive Summary which includes the key funding strategies for Proposition 63 funds.

You can download a copy of the Draft Plan and the Executive Summary from:  
[www.sfdph.org/Prop63](http://www.sfdph.org/Prop63).

You can also review copies of the Draft Plan and the Executive Summary at the following four places:

Government Information Center  
Main Branch, 5th Floor  
San Francisco Public Library  
Civic Center

Clerk, Board of Supervisors  
City Hall, Room 244  
One Carleton Goodlett Way  
Civic Center

Mental Health Board office  
1380 Howard, 5th Floor  
(at the corner of 10th Street)  
from 8:30 a.m. to 5 p.m. weekdays  
415-255-3474

Mental Health Association  
870 Market Street, Suite 928  
San Francisco, CA 94102  
9 a.m. to 5 p.m. weekdays  
415-421-2926  
please call to make appt.

If you need to have a copy of the Draft Plan sent to you please let the Mental Health Board know at [mhb@igc.org](mailto:mhb@igc.org) or 415-255-3474 and we'll send one right out.

It is expected that there will be a very large turnout for each of the hearings, which means that each person will probably only have 2-3 minutes to speak.

Therefore, we welcome written statements ahead of time. You do not have to wait until the hearing date to submit written responses to the Draft Plan. Please send your statement as soon as you have it completed to the Mental Health Board.

We prefer that statements be e-mailed if possible to: [Helynna.Brooke@sfdph.org](mailto:Helynna.Brooke@sfdph.org). If you don't have internet access, please mail your statement to: Mental Health Board, 1380 Howard Street, Suite 510, San Francisco, CA 94103, or fax it to 415-255-3760.

You can also make comments through the Prop 63 website at: [www.sfdph.org/Prop63](http://www.sfdph.org/Prop63).

We'd like to ask you to make your recommendations as specific as possible. Let us know exactly how you want the money to be spent and why. Please feel free to write out the exact wording you'd like to see added into the Plan or changed in the Plan.

The Mental Health Board will be prepare a report on the written and spoken testimony about the Plan and will send this report to the Department of Public Health.

If you have questions about the Mental Health Board hearings, please feel free to call the Mental Health Board office at 415-255-3474.

### DISABILITY ACCESS

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD). Five days notice before the meeting will help to ensure the presence of an ASL interpreter or sound enhancement system. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.
2. For the October 22nd meeting, the Joseph Lee Recreation Center is wheelchair accessible, and the MUNI bus #15 Third Street is wheelchair accessible. For the October 24th meeting, City Hall is wheelchair accessible, and the #47 Van Ness bus is wheelchair accessible. The nearest MUNI Metro station is the Van Ness Station. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.
3. Both meeting sites are wheelchair accessible.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

#### **POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES**

The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

#### **KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE**

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Frank Darby, Sunshine Administrator  
Sunshine Ordinance Task Force  
City Hall, Room 244  
1 Dr. Carlton B. Goodlett Place  
San Francisco, CA 94102-4689  
Telephone: (415)554-7724  
Fax: 4(15) 554-5163  
E-mail: [sotf@sfgov.org](mailto:sotf@sfgov.org)

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from Ms. Hall, or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: [www.sfgov.org/sunshine.htm](http://www.sfgov.org/sunshine.htm)

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: [www.sfgov.org/mental\\_health](http://www.sfgov.org/mental_health). You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

#### **Lobbyist Registration and Reporting Requirements**

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site [www.sfgov.org/ethics](http://www.sfgov.org/ethics).





## Executive Summary

### Overview

In November 2004 the voters of California passed Proposition 63, the Mental Health Services Act (MHSA). The MHSA imposes a 1% tax on incomes in excess of \$1,000,000 dollars. Funds collected under the MHSA are to be used to fundamentally change access to, and delivery of mental health services throughout California.

Under the MHSA, each County will receive a percentage of available funds based on a complex formula developed by the State Department of Mental Health. According to the goals of the initiative, funds are to be used for the transformation of each County's mental health system into one that is consumer and family driven, recovery oriented, guided by best practices, and informed by outcomes.

The MHSA funds available to Counties in the first phase of MHSA implementation are those for Community Services and Supports. In order to be eligible to receive these funds, each County must submit an initial three-year plan developed through an open and inclusive community planning process that specifies how funds will be used to achieve the goals of the MHSA. The executive summary provides a brief overview of the planning process and the resulting plan.

It is important to note before describing San Francisco's planning process and the outcomes of that process, that the citizens of San Francisco broadly supported Proposition 63 with approximately 74% of voters supporting the measure in November 2004. Early media estimates projected that San Francisco would receive \$50 million or more in funding based on the high rates of mental illness and homelessness in the City. The community embraced the opportunity to participate in the extensive planning process as evidenced by the universally high number of community members participating in all planning activities.

Midway through the planning process, San Francisco's actual allocation of MHSA funds was determined to be significantly below early projections, at \$5.3 million for client services. While there was consensus that this funding was grossly inadequate to meet the City's multiple needs, the planning process continued with the goals of initiating services to address the most urgently needed priorities and documenting the remaining need to support unfunded priorities. In addition, the remarkable level of community participation in the planning process will continue to influence provision of behavioral health services throughout the City system.

### Where We Are Going

*It is our vision that all members of our community, young and old, who experience behavioral health challenges should lead happy, productive, and fulfilling lives, free of stigma, in a safe and least restrictive environment, and receive relevant and effective services from a comprehensive Behavioral Health System that is recovery-oriented and culturally-competent.*

- Vision Statement, The San Francisco Behavioral Health Innovations Task Force 2005

The San Francisco Department of Public Health (DPH) has been engaged with the San Francisco community in a process to achieve the goals of the California Mental Health Services Act (MHSA) and the President's New Freedom Commission Report. In March 2005, Mayor Gavin Newsom appointed Deputy Director of Health, Barbara A. Garcia to lead a 41-member, citywide taskforce in that effort.

The Behavioral Health Innovations Task Force (BHIFT) has developed an initial 3-year MHSA funding plan for submission to the State consistent with the Task Force's adopted Vision, Goals, and Guiding Principles, and the requirements of the MHSA. This document summarizes the 3-year plan and reflects the process that the Behavioral Health Innovations Task Force, engaged in to develop the Plan. The 3-Year Plan was informed by: a) the community, particularly consumers, their families, and behavioral health practitioners, b) current behavioral health needs data, and c) evidence-based practices and policies. It should be noted that the 3-Year Plan is an application to the State for funding under the MHSA and that a comprehensive work plan is being written to operationalize the information submitted to the State. The plan also builds upon and coordinates with a DPH process in progress since 2003 to combine Mental Health and Substance Abuse services into an integrated system of Community Behavioral Health Services (CBHS). The CBHS integration process includes a vision echoed by the BHITF where all consumers can easily access care in a system where "any door is the right door". While the planning for the CBHS process preceded the MHSA plan development, the work done to create a welcoming and accessible system for all consumers including those with co-occurring disorders, provided a foundation for the MHSA plan. Implementation of MHSA services and the final CBHS integration process will coincide and be complementary.

Recovery, cultural and linguistic competence, consumer and family involvement, stigma reduction, and the elimination of disparities in mental health care are central to the plan and the identified priorities. Although true transformation will require an on-going commitment far beyond the first three years, San Francisco will begin this transformative process by prioritizing and addressing the most urgent needs. The following points developed by the BHITF (a-k) will serve as guiding lights as we move through the years toward our vision.

- a) All consumers will be appropriately served with culturally competent, consumer-centered, integrated services that serve to reduce placement in hospitals, jails, Youth Guidance Center, emergency shelters and the streets.
- b) Alternatives to the use of emergency shelters, Institutes for Mental Disease (IMDs), skilled nursing facilities, hospitals, jails, and the Youth Guidance Center (YGC) will be expanded, especially targeting those who are currently unserved and underserved.
- c) Consumers and their family members will work with service providers to create a plan for preventing relapse and recidivism at intake into hospitals, jail, shelters, YGC and other placements.
- d) The City and County will continually invest in training and education of consumers, families and service providers to reduce the stigma of mental illness and to foster the vision and values of an integrated behavioral health care system.

- e) The structure and composition of services and supports will be designed so that consumers and family members will have easy access in obtaining services and supports including prevention, intervention and crisis services.
- f) Funding will be leveraged across City and County Systems to ensure integrated services and to maximize resources for consumers and their families in obtaining and maintaining recovery and wellness.
- g) Prevention and early intervention services will be enhanced throughout the service delivery system to help minimize chronic and severe mental illness in all age groups.
- h) A 24-hour, 7-day a week drop in center staffed by peers and professionals will be developed to help to divert people from Psychiatric Emergency Services (PES), hospital, jail, and other restrictive settings.
- i) Vocational training and education will be recognized as a cornerstone of all treatment and services. Consumers and family members will have access to these services and supports, and consumers will receive vocational training and education and will be hired widely throughout CBHS and contracting agencies
- j) All services, supports and programs will be evaluated using both systems-level indicators and consumer-level quality-of-life indicators, producing both quantitative and qualitative data. These outcome evaluations will be accessible and easily understood by the community, and will derive from an integrated data system that will maintain consumer and family confidentiality.
- k) Outcomes will be measured and reported to ensure that consumers experience a higher quality of life and that stays in high-end facilities are minimized, that homelessness diminishes, and that recovery and wellness proliferate. These outcomes will be used to inform policy and resource allocation.

## Identifying First Priorities

### **1. Outreach and Engagement**

San Francisco has a proud tradition of engaging the community and including diverse groups in public policy decisions. The MHSA planning process paid tribute to that tradition and far surpassed previous levels of consumer outreach. The Behavioral Health Innovations Task Force held over 70 meetings between April and August of 2005 to ask consumers, their families, service providers, and other members of the community what is missing from mental health services in San Francisco, and what they would like to see changed. Outreach included flyers, Internet, email, and in-person engagement efforts (in English, Spanish and Cantonese) and took into account the distinctive culture of each of San Francisco's neighborhoods. Meetings were organized to maximize involvement from different communities, and to invite discussion on focused topics (unmet needs, cultural competency, wellness and recovery, integrated services, etc.). Task Force meeting locations rotated to make it convenient for members of communities throughout San Francisco to attend at least one meeting.

Information collected during the planning process, including position papers, provider surveys, results of peer-to-peer interviews, penetration analyses, transcripts and summaries of meetings, and usage analyses were submitted to the Task Force for consideration and incorporation into the final plan. Consumer and family member input was an integral part of all information gathering

activities including 25% consumer representation on the Task Force. In addition, the plan is available for public review and comment for 30 days, and all comments received will be incorporated into the final plan.

## **2. What We Learned**

Many issues emerged from the extended deep listening and learning process including the understanding that we have a long way to go before the vision of a truly transformed mental health system is realized. Specific issues that emerged were:

- While consumers in San Francisco are offered more recovery-based programming and active involvement in their own recovery than are consumers in other systems, many consumers and families still experience services as fragmented and hard to access.
- San Francisco's Sheriff's Department and Police Force are better informed about mental health needs than many other Counties
- San Francisco's direct service providers are diverse and often bilingual
- Top officials recognize the importance of the self-help movement
- Paralyzing stigma around mental health plagues the Asian and Latino communities
- More "least-restrictive" alternatives need to be available and used to divert African Americans and others from jails, juvenile hall and mental hospitals
- Services are not fully integrated for consumers with co-occurring disorders
- There are hundreds of consumers for whom services are not available in the language they speak
- Transitional Age Youth fall through the cracks when they age out of foster care
- Early intervention could be improved if there were more access to mental health services through primary care
- Homeless consumers have many needs that are not being met
- Very few consumers and families are full and active partners in their own recovery

In sum, we learned that San Francisco is in a perfect position to make dramatic changes to the way mental health services are experienced. The Behavioral Health system has strengths to draw upon, compelling need, and the Department of Public Health, the Mayor, and consumers and community members are aware of what needs to change, and are willing to commit their time to enacting those changes.

## **3. Priorities Chosen for Each Age Group**

In response to MHSA funding requirements, discussions were organized by four different age categories, and sequentially ordered priorities from the deep listening and learning process are listed according to these categories: Children Youth and Families, Transitional Age Youth (16-25), Adults (18-59), and Older Adults (60 and older).<sup>1</sup> While many issues surfaced for each age cohort,

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<sup>1</sup> The detailed results of the prioritization process are attached to the plan as Appendix 6, which includes tables for each age group as well as service provider survey reports.

the amount of money available through the Mental Health Services Act is limited, so the long lists had to be reduced to include just the top priorities for each age group. These shorter lists were determined through voting and are shown in the box below. They are a small fraction of the needs identified through the consensus process over many months, but they represent the beginning points identified by the task force and community.

Children/Youth	Transitional Age Youth	Adults	Older Adults
1. Trauma resulting from witnessing of or being a victim of violence	1. Homelessness	1. Homelessness	1. Isolation
2. Juvenile Justice/Child Welfare system involvement	2. Youth aging out of the Child Welfare System	2. Incarceration	2. Hospitalization
3. Homelessness	3. Juvenile Justice System involvement	3. Hospitalization	3. Homelessness
4. Mental illness co-occurring with autism	4. Suicide	4. Suicide	4. Dementia
5. Undocumented	5. Lack of employment and inability to work	5. Inability to work	5. Suicide
6. Suicide	6. Trauma resulting from witnessing of or being a victim of violence	6. Trauma resulting from witnessing of or being a victim of violence	
	7. First break prevention management		

### **First Steps Toward the Vision**

Beginning to address all of the age-specific issues that came out of the planning process will involve two different approaches, in compliance with MHSA requirements. The first strategy is to maximize the number of consumers from each age group entering into full service partnerships, focusing especially on populations at risk for the priority issues. The second strategy is to improve the systems that serve people at risk for the priority issues, so that these systems are more recovery-based, accessible and consumer-centered.

#### **1. Full-Service Partnerships**

In accordance with MHSA specifications, San Francisco will use the majority (51%) of Community Services and Support (CSS) funding for Full Service Partnerships. In short, Full Service Partnerships means that consumers become true partners in their recovery plans, and it means doing "whatever it takes" to make an impact on people's lives in terms of housing, relationships, resources during crisis, education and employment, and fewer involuntary services. Each individual identified as part of the initial full service population will be offered a partnership with the county mental health program to develop an individualized services and supports plan, based upon principles of recovery and wellness.



Given the limited funding, estimated 5.3 million for services, and the priorities that emerged from the planning process, a total of **122-153** individuals and families per year will be part of the initial full service population for these first three-years, as follows:

**Children Youth and Families:** In the first three years, we will fully serve **27-34** children, youth and families, focusing on children and youth who have been exposed to violence, in Child Protective Services, in Foster Care, in the Juvenile Justice system, and those who are homeless.

**Transitional Age Youth:** Full service partnerships will be offered to **34-43** transitional age youth between the ages of 16 and 25. We will focus on youth who have been exposed to violence, who are homeless, who have aged out of foster care, who are immigrants, and those who are immigrants.

**Adults:** Between **27** and **34** adults will be served in full service partnerships, with an emphasis on homeless and Veteran adults, women with children, victims of violence, adults in jail, and adults who appear to be inappropriately served by the system as evidenced by a "revolving door" of relapse.

**Older Adults:** In providing full service partnerships to **34-43** older adults and seniors, we will target those who are hospitalized in high levels of care, those in Adult Protective Services, the homeless, monolingual older adults, and those who are particularly isolated.

## **2. System Development**

By way of addressing the identified priorities for individuals beyond the 153 who can be served with full service partnerships, San Francisco will use the remaining 49% of CSS funding for systems development. The Mental Health side of CBHS currently serves over 2300 unique consumers each year with an additional 11,280 individuals receiving treatment from the substance abuse side. Funds will be used to improve programs, services and supports for the identified initial full service populations. General system development funds will help to improve programs, services and supports for all clients and families (including but not limited to initial Full Service Partnership populations) to change service delivery systems. These efforts will include strategies for reducing ethnic disparities and for outreach and engagement of populations that are currently receiving little or no service. Eliminating ethnic disparities and reaching people who are currently unserved and underserved is a primary focus of this plan and of San Francisco's transformation in mental health.

Again by age category, the system development funds will be specifically dispensed in the following ways:

### **Children Youth and Families:**

- ❖ \$120,000 will be used to serve 100 children and youth each year for three years in community-based violence and trauma recovery services, including a peer-support component for youth.
- ❖ \$120,000 will be used in integrating psychiatric services within pediatric settings for early identification of mental health and psychiatric needs.
- ❖ \$121,490 will be used to increase organizational and clinical capacity to specifically serve Lesbian, Gay, Bisexual, and Transgender, Asian/Pacific Island, indigenous, Latino and African American children and youth with culturally appropriate services.
- ❖ \$80,000 will be used in school-based services including wellness centers.



### Transitional Age Youth:

- ❖ \$162,836 will be used to integrate behavioral health services within primary care settings that serve transitional age youth.
- ❖ \$200,000 will be used to provide supported services for housing, including co-op housing, independent living and board and care.
- ❖ \$300,000 will be used to do outreach and engagement and to support youth-run and youth-developed services using the Youth Development Model.

### Adults:

- ❖ \$131,490 will be used for supportive services for housing, including peer case management.
- ❖ \$100,000 will be used for Vocational Rehabilitation. Through a partnership with the Department of Rehabilitation, this funding will expand to \$400,000, as they will match \$3 for each \$1 of CSS money spent.
- ❖ \$130,000 will be used to support a peer-run center that will include crisis drop-in and a 24-7 warm line.
- ❖ \$80,000 will go to residential treatment.

### Older Adult:

- ❖ \$180,000 will be used to support a senior recovery center that offers peer support and outreach.
- ❖ \$300,000 will be used to provide supportive services for housing including peer case management.
- ❖ \$172,836 will be used for mental health services in primary care settings, including dementia behavior management.

The table below provides a snapshot of funding for Full Service Partnerships and System Development activities as they apply to some specific target populations and service categories. This table was developed using the following assumptions: 25% of all people served in FSP and through System Development will be homeless, 25% of all people served in FSP and through System Development will be victims of or exposed to violence, 15% of new staff hired to administer FSPs will be peers or family members.

Service Activity/Target Population	FSP ———	System Dev ———	Total ———
Housing Services	\$574,388 (25%)	\$711,490	\$1,285,878 (29%)
Violence related services	\$574,388 (25%)	\$641,363	\$1,215,750 (27%)
Peer run services	\$344,633 (15%)	\$831,490	\$1,176,123 (26%)
Services at Primary Care		\$445,670 (10%)	\$ 445,670 (10%)

## **Measuring Progress**

All of this money will be meaningless if actual changes do not result from the efforts we implement. We plan to learn from evaluations and make sure that the programs make a measurable difference in the lives of the people they serve. Below are the ways we plan to measure progress in transforming the mental health system.

### **1. Full Service Partnerships Goals**

We anticipate measurable change to result from the efforts outlined in the MHSA plan for the first three years. We also expect, as the process continues beyond year three, that momentum will increase, and that the changes will continue and grow. The following goals will be met with the 153 individuals in Full Service Partnerships (FSP) during the three-year plan; similar impacts will be measured among more Full Service Partnerships in subsequent years.

- There will be a reduction in the use of jail, juvenile detention, and mental hospitals for individuals in FSP.
- Clients will demonstrate improvements in quality-of-life measures such as:
  - Safe and adequate housing
  - Meaningful use of time, such as increased employment, vocational training, education and social and community activities
  - Supportive relationships
  - Timely access to needed help, including times of crisis
  - Reduction in incarceration, hospitalization, involuntary services and out of home placements.
- Vocational training and self-help will result in greater autonomy and employment for FSP clients.
- Clients with co-occurring disorders will experience more appropriate recovery assistance and will report improvements on all fronts.
- Clients will receive services that are culturally competent and in the language they are most comfortable speaking.

### **2. Systems Development**

With the 49% of funds that go toward Systems Development, we expect to accomplish the following:

- ✓ Integrate consumer and family member involvement at every level of the organization including governance and service delivery – as volunteers and staff (professional and para-professionals).
  - Consumers and family members will be supported and provided assistance to serve on all Boards of Directors and Advisory Boards, and organizations will be encouraged and assisted to build consumer and family member involvement on their Boards of Directors and Advisory Boards.

- ☐ Consumers and family members will receive education and training on working with Boards, advisory boards, and within CBHS.
- ☐ Employment opportunities for consumers will be created and supported.
- ☐ Staff and volunteers will receive education and training to work with consumers and family members as full partners.
- ✓ Provide services that are non-stigmatizing and are community-based, ideally located where people naturally go, such as schools, health clinics, and community organizations.
- ✓ Ensure that decisions regarding individual care and services are made with the consumers, and family members when appropriate.
- ✓ Ensure that for children, decisions regarding individual care and services are made by and with the family or the identified responsible parties.
- ✓ Ensure that family members are heard in planning and service delivery.
- ✓ Provide services that build on strengths of consumers of all ages.
  - ☐ Service providers (medical staff, case managers, and so on) receive training and education on how to communicate most effectively with family members, while following confidentiality laws.
  - ☐ Family members receive training and education about mental illness and effective advocacy for family members
- ✓ Provide prevention and early intervention services, that will help divert people from hospitals, jails, homelessness and the Youth Guidance Center.
- ✓ Provide culturally competent education, which includes youth culture, to all service providers at all levels of care to reduce the stigma of mental illness.
- ✓ Provide culturally competent and linguistically appropriate services.
- ✓ Provide services that foster wellness and recovery and are evidence-based practices.
- ✓ Ensure that consumers receive fully integrated health care services – mental health, substance abuse and primary care – that work collaboratively with other systems such as social services and justice systems so that care plans and treatment are coordinated.

## **The Long Road to Fulfilling the Vision**

### **1. How \$10 Million Transforms \$200 Million**

The MHSA money amounts to a total of \$10 million, which is very little considering the mental health needs of San Francisco. Clearly, the MHSA funding will not be enough to truly transform the system all by itself, but the MHSA plan will set the process of transformation in motion. In other words, these plans for full service partnerships and system development will act as a catalyst for the larger mental health care system of San Francisco, which has a total budget of \$200 million and has an impact on thousands each year. The planning process itself has involved outreach to the consumer and family community in an unprecedented way, engaging consumers who have never been involved in consumer-advocacy groups in actual policy decisions. The long lists of priorities that the listening and learning process revealed will continue to shape decision-making, and future oversight will always involve consumer participation. The recovery and self-help

movements have touched San Francisco in an irreversible way that will impact future spending decisions.

## **2. Building on Strengths to Change the Culture of Mental Health Services**

San Francisco is primed for a different approach to mental health, one that builds on the budding achievements already accomplished here. In San Francisco, there are currently providers who embrace recovery, wellness and resiliency models for mental health. The planning process revealed that there is growth that must take place in this approach system-wide, but the work that has already been done sets the stage for this three-year plan to yield successful outcomes. Similarly, building cultural and linguistic capacity, employing least-restrictive approaches, applying early detection and intervention strategies, and making sure that practices are outcome-driven are all valued by San Francisco. But these concepts have not been the *driving* force behind funding and programming decisions, until now. The Full Service Partnerships and the system development plans outlined in this plan are San Francisco's first steps toward a very different, consumer-centered approach to mental health. These steps will be measured carefully to monitor how successful these efforts are in changing people's lives.

### **The Plan**

#### **1. Why this Plan Was Written**

The MHSA CSS plan for the City and County of San Francisco was written in response to California's Proposition 63, passed by voters in November 2004. The initiative is meant to provide funding for community-based mental health services and supports in every county in the State. San Francisco prepared this three-year plan, and submits it to the public for review before submitting it to the State. It will be reviewed annually, in accordance with the requirements of the Mental Health Service Act. The structure of the plan was determined by the California Department of Mental Health, and the content came from the extended community planning process that began in February 2005 that continues to give guidance.

#### **2. How to Read the Plan**

With the exception of the Executive Summary, the plan was written in strict accordance with the structure delineated by the Mental Health Services Act. Headings and subheadings in the 120+ page document are all derived from questions the state required to be answered in the plan. The plan is divided into two Parts and several subsections, and is followed by several appendixes and attachments. Below is a brief guide to the lengthy plan.

- a) Part I: Provides a detailed account of how community outreach was conducted to ensure consumer and family participation in the planning process.
- b) Part II Section I: Discussed the priorities that were identified for each MHSA-designated age cohort and why they are prioritized.
- c) Part II Section II: Describes the unserved and underserved populations in San Francisco and discusses ethnic and cultural disparities, using county data.
- d) Part II Section III: Discusses Full Service Partnerships populations and how and why they were selected.
- e) Part II Section IV: Discusses the proposed MHSA-funded programs and strategies.

f) Part II Section V: Discusses the strengths and limitations of the current system's cultural and linguistic capacity.

g) Part III: Required Exhibits

h) Appendixes and Attachments: Notes from planning meetings, other state forms and tables that clarify the planning process are attached at the end of the plan.





## SAN FRANCISCO MENTAL HEALTH BOARD

Gavin Newsom  
Mayor

1380 Howard Street, Suite 510  
San Francisco, CA 94103  
(415) 255-3474 fax: 255-3760  
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[www.sfgov.org/mental\\_health](http://www.sfgov.org/mental_health)

### MEETING OF THE MENTAL HEALTH BOARD

Saturday, October 22, 2005  
Joseph Lee Recreation Center  
1395 Mendell Street  
(at Oakdale & 3rd St.)  
1 p.m. to 4 p.m.

DOCUMENTS DEPT.

SEP 23 2005

### AGENDA

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#### CALL TO ORDER

09-23-05 A08:02 RCV

#### ROLL CALL

#### AGENDA CHANGES

#### Item 1.0 PUBLIC HEARING ON THE DRAFT PLAN FOR SAN FRANCISCO'S PROPOSITION 63 FUNDING

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The Plan is available to review or download at [www.sfdph.org/Prop63](http://www.sfdph.org/Prop63).

The Plan is available for review at the following four places:

Government Information Center  
Main Branch, 5th Floor  
San Francisco Public Library  
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Clerk, Board of Supervisors  
City Hall, Room 244  
One Carleton Goodlett Way  
Civic Center

Mental Health Board office  
1380 Howard, 5th Floor  
(at the corner of 10th Street)  
from 8:30 a.m. to 5 p.m. weekdays  
415-255-3474

Mental Health Association  
870 Market Street, Suite 928  
San Francisco, CA 94102  
9 a.m. to 5 p.m. weekdays  
415-421-2926

To request that a copy of the plan be sent to you contact the Mental Health Board at 415-255-3474 or [mhb@igc.org](mailto:mhb@igc.org) or 1380 Howard Street #510, San Francisco, CA 94103.

#### ADJOURNMENT



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3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley which runs on the opposite side of the building from 10th Street.
4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

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San Francisco, CA 94102-4689  
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SEP 23 2005

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09-23-05 P04:12 RCYD

**CALL TO ORDER**

**ROLL CALL**

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## **Item 2.0 PUBLIC COMMENT**

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DOCUMENTS DEPT.

OCT 20 2005

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### UPDATED AGENDA

#### CALL TO ORDER

#### ROLL CALL

#### AGENDA CHANGES

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#### Item 2.0 BOARD RECOMMENDATIONS ON THE DRAFT PLAN

For discussion and possible action.

2.1 PROPOSED RESOLUTION: The Mental Health Board hereby forwards the following recommendations to the Department of Public Health in response to public comment regarding the Draft Plan for the Mental Health Services Act....

2.2 PROPOSED RESOLUTION: The Mental Health Board hereby forwards the following official recommendations of the Mental Health Board to the Department of Public Health regarding the Draft Plan for the Mental Health Services Act....

2.3. PROPOSED RESOLUTION: The Mental Health Board hereby forwards the following recommendations to the Department of Public Health from individual Board members regarding the Draft Plan for the Mental Health Services Act.

#### Item 3.0 PUBLIC COMMENT

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#### ADJOURNMENT



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2. For the October 22nd meeting, the Joseph Lee Recreation Center is wheelchair accessible, and the MUNI bus **#15 Third Street** is wheelchair accessible. For the October 24th meeting, City Hall is wheelchair accessible, and the **#47 Van Ness** bus is wheelchair accessible. The nearest MUNI Metro station is the **Van Ness Station**. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.
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### **Lobbyist Registration and Reporting Requirements**

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MINUTES OF PUBLIC HEARING  
ON THE MENTAL HEALTH SERVICES ACT (PROPOSITION 63)

Mental Health Board  
Saturday, October 22, 2005  
1:00 p.m.

DOCUMENTS DEPT.

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This meeting was held at  
The Joseph Lee Recreation Center  
1395 Mendell Street  
San Francisco, CA 94124

MEMBERS PRESENT: Rebecca Turner, Ph.D. (Chair); Benito Casados; LaVaughn Kellum-King; James Shaye Keys; Claudia Lebish; James L. McGhee; Toye Moses, Ph.D., M.P.H.; Tom Purvis; Jagruti Shukla, M.D., M.P.H.; Kate Walker; Lisa L. Williams; Idell B. Wilson.

MEMBERS ABSENT: Bob Douglas; Supervisor Bevan Dufty; John Kevin Hines; Dorothy Shaffer, R.N., N.P., M.S.N.

CALL TO ORDER

This public hearing was called to order at 1:13 p.m. by Rebecca Turner, Chair.

AGENDA CHANGES

There were no changes to the agenda.

REBECCA TURNER: Good afternoon, everybody. Thank you very much for attending the first of the hearings by the San Francisco Mental Health Board for the City draft Plan for Proposition 63 funds, the Mental Health Services Act. We're really pleased to facilitate this hearing today, and we really appreciate your coming out to show your interest, and your support.

What we're going to do first of all – I know people have received a very long, voluminous plan, and hopefully also a couple of executive summaries, which are much briefer, and much easier to read. But also, we asked Dr. Cabaj, the Director of Community Behavioral Health Services, to be here to give you a brief overview – perhaps just ten minutes – of the Plan. And at the conclusion of his statement, if you have any specific clarifying questions, we have an opportunity to take just a couple of questions. Obviously, we want to move forward with our hearing, so we won't spend a lot of time on questions. But if there are a couple of things where you really feel that you need to clarify something that was said, please raise your hand, and we'll call on you.

After that, we have a series of yellow cards here that people have filled out. Antonio Morgan over there, who's gonna be the first speaker, is holding for you – you can fill one of these out, and we will then call your name and recognize you, to make a three minute comment. And if we have time at the end, we'll have opportunities for additional people to come back. But we can be here only until 4:00 o'clock today, so we have to keep moving along. Thank you again, and I'm gonna ask – oh yes! And I wanted to announce, also, that there is an assistive listening system available for anybody who needs it.

Just after Dr. Cabaj speaks, I'm gonna ask the translators to come up also, to let people know that we have translation services available. Okay, whoops – Dr. Cabaj is still back with the TV folks, being interviewed, so I'm gonna ask the translators to please come up and let us know about your services that are available. (The translators introduce themselves.) thank you very much – we appreciate that. (Pause).

We still have a few minutes while we're waiting for Dr. Cabaj, so I think we'll step up our introduction, and do that right away. I'd like for each of the Board members to just introduce themselves – just take a minute, and say who you are, and who you represent. (Board members introduce themselves.)

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BOB CABAJ: And I'm not a Board member, but I'm Dr. Bob Cabaj, I'm the Director of Community Behavioral Health Services – and this Mental Health Board and I work together very closely – so thank you.

REBECCA TURNER: (Introduces Helynna Brooke and Rich Snowdon.) Okay. And I now want to ask Dr. Cabaj – he's not a member of the Board, but because we asked him to come here on Saturday afternoon, to give us an overview – as he's been extremely involved in this process, we asked him to please sit at the table with us, and just give us a ten minute overview. Thank you, Dr. Cabaj.

BOB CABAJ: Thank you very much. I appreciate this opportunity to speak with you. I know the acoustics aren't great, so I hope you can hear me, and I'll speak a little slowly, 'cause when I was in back, I heard a lot of echo.

The role I play is that, when the Plan is amended, after the public hearings we have today and on Monday, then the Plan will be revised and edited. And I am the, what is called "the Mental Health Administrator" for the County of San Francisco. So I am the one who will officially submit the Plan to Sacramento, the Department of Mental Health. And then I will be working with the State in negotiating their approval of the Plan, which we hope will happen.

Let me just give you a quick overview of the Plan itself – a little bit of the planning process and the Plan – 'cause I know we want to spend most of our time looking at the details, and your reactions to it.

As we know, the Act was called the – Proposition 63 – in November in San Francisco by the widest margin of votes, which shows you how well aware we are of the needs for additional mental health services. The goal is to make sure that everyone knows mental health is a serious condition that needs treatment and intervention. The money is, as you know, a tax on anyone with over a million dollars, and there are plenty of those people in California, so we will have a base of money. We were a little disappointed with the total we have for the clinical service piece, but that, per year, is 5.3 million.

What we did was, have a major planning process. The Mayor appointed a Task Force. Many of you in the audience have actually been members of it, or attended Task Force meetings. And Barbara Garcia was the chairperson of that Task Force. The Task Force met seven times in seven different neighborhoods. In addition, there were eleven different subcommittees that looked at population issues, as well as issues such as housing, homelessness, education, work rehab, and so on. And there were over 66 meetings of those committees, and there were various other attempts to meet with individuals, groups, neighborhoods, and this was all done with the great work of our consultants, RDA, and they are also in the audience, and can help us if there are any particular questions.

The best things in the Plan – 'cause the Plan, you can see, is not easy to read – the 200 page document is meant as a filling-in of questions that the State required us to answer – so it's not fun reading. In fact, I recommend if you have insomnia, to try to read a lot of it all at once. But if you look at it carefully, it has some nice sections. The vision and the principles are outstanding, and the Task Force did a lot of work in creating the visions that we want to have for our system, which is a consumer sensitive, family oriented, community based, evidence based, run, recovery modeled program. And it's very hard to capture the spirit of that in the Plan. So I do urge you to read the executive summary, if you haven't. There's a longer version of that – it's about eleven pages – it's excellent. And then there's a very condensed, two page version with one table, which we created for the Health Commission and the Board of Supervisors, both of whom have already supported the moving ahead of this Plan. But it has things such as making sure that organizations that supply services to us are very aware of consumer and family issues, trained in the recovery model, and have consumers and family members on their boards of directors, and so on.

Basically, the Plan is designed to tell us what to do with the 5.3 million. In the hearings, we distilled hundreds and hundreds of ideas, and we tried to group them into certain packages. And those ideas were listed in non-ranked order, and then voted on by the Task Force members, so that we could rank order what was considered the top things, and not. Although all the items were important, since we had such limited funding, we could only pick a few areas.

The State requires us to make sure we cover four major age groups – children and youth, transitional age youth (which they describe as age sixteen to 24), adult, and older adult. We therefore took the money and divided it up among the four populations. And then they also said, at least 51 percent of the dollars have to be used for something they call "full service partnership". And what that is, if anybody knows some of the current mental health and behavioral health treatments – it's a variation of intensive case management. And it's sort of, "Do whatever it takes to help somebody get better, and to get the

services that they need.” So that includes things like our AB-2034 programs, the intensive case management, and what we call “assertive community treatment teams” – these are our ACT teams that are already working in the City. So the money would be used to enhance care, so we can add additional services for more clients.

Again, given the amount of money they gave us, the most we think we can treat is about 150 new clients, which doesn’t sound like a lot, per year. But we hope to be able to balance some additional revenues that we get from this, and we ideally will treat even more people.

The other 49 percent of the money is used for that they call either “systems development” or “outreach and engagement”. And what they meant here was, what do we need to create – either new systems, new services, new sites in our city – that could then meet the goals of getting our system transformed so it would be more sensitive to the family needs, to the clients’ needs, to the recovery model. And we decided that, since we still had so little money, we would put all 49 percent into system development, versus outreach. It doesn’t make sense to do a lot of outreach if there aren’t services available. But a lot of what we call “systems development” includes outreach. And the Plan, the appendix of the Plan actually, details how we would like to use that money for various things.

I won’t walk through all the details, but for example, when it comes to children and youth, we want a portion of the money to be used for recovery based services that are for people who are victims of violence or trauma, or who have witnessed violence and trauma. We obviously know that’s a HUGE need in the community.

We also recognize that there are a lot of conditions that youth, transitional age youth, adults and older adults – all get their care through a primary care provider. And sometimes the only contact somebody has is with their medical doctor or nurse, and we want to make sure there’s better mental health and substance abuse services available at primary care clinics. So a good portion of money for each age group will go to support services at primary care clinics.

We also know we have to have some specific centers for culturally focused areas, and that would include African American, Latino, Asian American, and gay, lesbian, bisexual and questioning youth. And we will – hope that we can get individual teams that can focus in those areas, and eventually get centers that can support those individuals.

For youth, we would also add more moneys toward school based services. And for transitional age youth, additional money for supported housing – ‘cause we learned that transitional age youth don’t do well in regular adult housing. But if we can get housing that’s more specific for their age group, that would help. With the adult level, in addition, we would ask for more vocational rehab money, and that is job creation and job enhancement. And with every single dollar we put towards that, we actually get three dollars from the State, so it’s a very good investment for us.

And for older adults, we would love to create a peer center, which would allow older adults and peers to have a safe place where people can go, spend some time, get services, and feel engaged and not isolated or lonely.

The theme through all of these, is that we want many more peer-run services, as well as peer counselors working in our system. And by that, I mean someone who’s a client or a former client in our system, but who goes through school, and trained to be a counselor or a therapist, and that they become part of our whole system of care. And we will urge that to happen – not just in the programs run directly by the City, but all the programs that are run by our contract agencies. And in our system, more than 70 percent of services are provided by our sister contract agencies, so we want them to be similar. We want everyone to have the same standards, as they approach this.

So our next step is to have you all give us some ideas of what your thoughts are to the Plan, and this is where the Mental Health Board plays the crucial role of taking on the public feedback, and working on ways to help amend the Plan.

So with that quick summary, I can turn this back to the Chair, please.

REBECCA TURNER: Dr. Cabaj, thank you so much. Let me just ask – is there anyone who has a question that you feel will help just to clarify the meaning of anything, for Dr. Cabaj? (Pause). Okay. I don’t see any hands – so we’re going to move forward with our hearing. (Asks Michael Medema to explain the hearing process, time-keeping, etc.)

Okay. So I’m gonna start by calling three names, just so you’ll kinda know when you’re up next. And I’ll also – a few other

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Board members – a few other Executive Committee Board members – James and Idell – will be helping me with this process as well, today. For the first three people – Antonio Morgan, Lena Miller, and Ruth Gravitt?

MICHAEL MEDEMA: And can you please make sure, when you get to the microphone, to say your name right before you start your testimony? Mr. Morgan?

ANTONIO MORGAN: Hello, everybody. I'm glad to see a good turnout today – people that have good concerns, and have a passion about this process that has gone on through the Mental Health Services Act. You gave up your Saturday to come here to make public comment to the Mental Health Board. I'll probably echo a lot of stuff that Bob Cabaj said – he talked about the executive summary – it's brilliant, I love it – but I think it should be included in the Plan.

It's good we talk about families – the family role is really important for people in mental health situations, and stuff like that. The family needs to be involved with treatment, with the recovery that those client needs, or the consumer needs, to better themselves, to live productive lives. Also, the family should be used as a resource and an ally, because they're the ones who deal with the clients. And also, due to confidentiality, some things they may not be able to tell the families, but the families need to be involved.

There also should be training for families, to provide them how to work with their loved ones. And also, I want to recommend that – this has been the talk the last couple weeks – that there be a consumer position available at high level, with Bob Cabaj, Director of Community Behavioral Health Services, to represent consumers. Because the consumer can provide guidance and input and insight on the mental health service vision that's gonna take place due to the Act.

And also... we want to, not just vocational training to be stipends. We want to see 'em be employed, get paid, and want the jobs to be supportive, and also to be on the job training. Them are my recommendations, thank you.

MICHAEL MEDEMA: Thank you, Antonio. (Pause). Lena?

LENA MILLER: Hi. My name is Lena Miller. I'm the founder of Girls 2000 – we're also called Hunter's Point Family, and that encompasses the Girls 2000 program that's on Harbor Road – Peacekeepers, that's in the Alice Griffith housing developments, and Bayview Safe Haven, which is located right here. And we serve youth, ages anywhere between twelve and 24, depending on the program. And over the years, a lot of our youth have either been involved, been victimized, or have witnessed a lot of the violence that's been going on.

We did a survey of our youth – 100 percent have a close friend or a family member that's been murdered within the last year, and about a quarter of them have actually witnessed some type of murder. And what we see is, a lot of times, that the mental health services aren't really accessible. I think there's a couple of layers between when people actually see something or experience something, and they get help – if they get help at all.

So I would just encourage the panel, or the people who are developing the Plan, to really find a way to make the services accessible. So again, that people aren't stigmatized, there's not a big leap – I think a lot of times, it's very difficult for young people to go into mental health service clinics. But if – I think – I saw this IN the Plan, so I know that you guys will consider it – but if you make mental health available within the programs that youth are already going to, then a lot of times, you can get to youth before they have a break, an episode, they kill somebody – because as most of you know, one of the biggest factors for why people actually act out violently is, not witnessing it, not seeing it, or having experienced it, but actually having been victimized themselves. And so usually if it's right there, it's with people they trust, they've BEEN around, then it's not such a leap to get the services.

So that's what I'd like to say. Also, not to underestimate how many youth have been touched by it. Because I think what we're seeing in all our youth, is that they're suffering from symptoms associated with post traumatic stress disorder. But the only difference, and I'll wrap this up, is that with post traumatic stress disorder, youth – or people experience an episode – they go to war, they come back, and it's over. And I think what we really need to be concerned about is, with our youth, it's never, ever over. It's at the bus stops, it's at schools, it's – it just keeps going and going and going. And to really consider the effects that that's having on them, long term. Thank you very much. (Pause).

MICHAEL MEDEMA: Thank you, Lena.

RUTH GRAVITT: Good afternoon, I am Ruth Gravitt. I would like to address the issue of the fifteen percent allocated to the hiring of seven people for the Mental Health Services Act process. I would just like to suggest that... people identified as consumers or clients be offered these positions preferentially, before they're offered to non-consumers. I am not sure if this fifteen percent is just for salaries, or if overhead costs are included – but I would not like to see high salaries given to individuals who don't identify as being consumers.

There are many recovered consumers who are highly functioning, and who are already working as program managers and executive directors of organizations. So I'm hoping this will not be seen as an unrealistic idea.

The only other thing I would like to promote today, is that the senior recovery center, which I advocated in a position paper – thank you very much that you put it in – would be located right here in the Bayview! I live in this neighborhood, I would like to help with this project. So it would be personally convenient to me – but more important than that, is that there is a very great need in this neighborhood, for the suffering seniors. We need a center where they can be taught to lead groups on diabetes management, which is rampant in this community – pain management, anger management, grief management, reminiscence therapy – a lot of these things that I know a lot about, and could help provide the materials – I would love to see that right here. Just an idea – I don't know if a place has already been selected, but if it hasn't, I would like to just promote that idea.

In conclusion, I want to thank all of you for what you are doing for the consumers, as consumers. This whole process has enabled my own recovery, such that someday, I hope to write my memoir, and I will title it, "From Acting Out to Activism". (Applause).

MICHAEL MEDEMA: And Ruth, I just want to acknowledge you in public, and say thank you to you, because you've been a part of the Older Adult Subcommittee from the very beginning, and you've seen this process all the way through, like many of us. And I just want to say thank you to you for your participation, and for dragging your husband to all these things, as well. I know he's enjoyed it with you. But thank you for your work, as well. (Applause).

REBECCA TURNER: And Ruth, since you've written out what you said, if you want to submit something in writing to us, we'll be sure that it's transcribed. Okay – and that goes for everyone. I'll read the next three names – oh, one other announcement – if there is someone here who has lost a set of keys, will you please let Helynnna know? Because she has found some, and you can just wave, and she'll come around, and – yes! Everybody check your keys right now...

MICHAEL MEDEMA: All of you at once (chuckles)...

REBECCA TURNER: ...check your pockets. Okay, let's have stand up, stretch, and check your pockets. (Chuckling from the group). Okay, three more names. Tuesday Clemmen, Kay Hockster, and Belinda Lyons.

TUESDAY CLEMMEN: Hi, I'm Tuesday Clemmen. Thank you guys for comin' out today. I'm here every day at the gym, and today was the first day I saw you guys advertise that you were gonna be here. And I know a lotta people in the community will love to come to this meeting, if they woulda knew about it ahead of time. I know a 63 year old lady that lives down the street, that she raised six of her grandchildren, and her oldest one is 36 years old. So her youngest one suffers from a mental health issue. And... that brings me up here right now. I think there should be more outreach, that you guys are coming out here to demonstrate what you guys are saying, since they – since we were the voters to vote on Prop 63.

My daughter – I have a ten year old daughter – she suffers from Down's syndrome with mental retardation, and she has HDD. And at my first IP(?) that I went to with her, I didn't know anything. (Pause). As the School Board was tellin' me what was best for her, wasn't. And as a parent going to different kind of meetings, I found out from another parent, "You have a right to speak on your child." And I think there should be more advocates in the health community, excuse me, in the mental health community, to let them know they have a right to speak on what they don't know. And there's also advocates out there to talk for them, if they don't know how to talk. And I think that's very important today, for me – and for the 60 year old lady that doesn't know the diagnosis of her IP, because it's in medical terms. So I told her, "Next time you go to your IP," I will be her advocate. Thank you. (Applause).

MICHAEL MEDEMA: Thank you. Kay?



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KAY HOCKSTER: Hi. My name is Kay Hockster, and I'm a consumer, and I want thank you very much, Doctor, for your summary, because that's what I know about this Plan. Because I have an eyesight problem. And you submitted written things in five languages. You submitted ways for people with hearing problems to get information, and two translators, but not one piece of information was submitted to us in large print. And that's discrimination, if nothing else. And I would really like that rectified as soon as possible. Thank you very much. (Applause).

MICHAEL MEDEMA: Thank you.

BELINDA LYONS: Good afternoon, I'm Belinda Lyons, represent the Mental Health Association of San Francisco, and I wanted to start by thanking the wonderful leadership of the Mental Health Board throughout this whole process, and also the hard work of the Department of Public Health, and the Resource Development Associates, and also the Task Force members.

The Mental Health Association has submitted a list of different recommendations for revision, so I won't go into all of that. But I thought I would just highlight a few of our main points. One of them is, we were all very disappointed by the five million dollar allocation. And I want to say that the way that we see this, is that the Mental Health Services Act money is an opportunity to use this five million dollars a year – first of all, we have the opportunity to increase that allocation. And secondly, the spirit and the vision of the Mental Health Services Act should actually be applied to the whole 200 million dollar budget. So we have 205 million dollars for systems transformation, not five million dollars a year. So that's one thing that we want to emphasize.

And we would like to see, in the Plan, that stated explicitly, and we'd like to see an explicit commitment to that – to transforming the entire system to the vision and the spirit of the Mental Health Services Act.

Supporting the comments that Antonio made, about the consumer involvement – the Plan from the State requires us to talk about how consumers are involved from the inception, implementation and evaluation of the whole implementation – in all of those stages of the Mental Health Services Act. We would like to see in the Plan further elaboration of exactly how consumers will be involved at each of those stages.

Definitely, the executive summary needs to be included into the Plan, and... I think I will stop there. But we have a full list of our recommendations – thanks very much. (Applause).

MICHAEL MEDEMA: Thank you Belinda, and thank you for all your efforts in this, as well.

REBECCA TURNER: Yeah, I think the Mental Health Association deserves a real special mention. Belinda Lyons, who just spoke, who's Executive Director, Antonio Morgan who spoke in the beginning, and also Alicia Hopper – they've been very involved in outreach for stakeholders. And they've been involved in everything from the very beginning, so we thank them enormously for their partnership. (Applause).

Okay. And next, just as I said – Alicia Hopper, Heidi Hamilton, and Marilyn Shields.

ALICIA HOPPER: Okay – so I didn't plan that – I just want to point that out (chuckling from the group). So my name is Alicia Hopper, and I'm also here representing the Mental Health Association of San Francisco, and I want to thank the Board, and thank Rich and Helynn for holding these hearings, and giving the public an opportunity to comment about the Plan. Like Belinda mentioned, we do have a full list of recommendations that we're going to be submitting. I have three, specifically, that I'm gonna talk about today.

The first one is, definitely making sure that all the language in the executive summary is incorporated into the Plan. That has – the executive summary, most of you have read, has a lot of clear language about consumer and family involvement, and kind of the vision of the Mental Health Services Act, so we want to make sure that's definitely included with the Plan.

My second point is, when the allocation formula first came out, one of our main concerns with it was the prevalence data that the State used. And that same data is also being used in the Mental Health Services Act plans. We want to make sure there's clear language in the Plan, that emphasizes that that prevalence data really underestimates the need in San Francisco – so just kind of some clear language around that.



My final point also relates to the low allocation that we received. We want to make sure there's some sort of justification and explanation included in the Plan, that explains what we could do with additional funds. I'm not sure what that would actually look like when it comes down to it, but we really need to emphasize to the State how great our need is in San Francisco, and to show them that we have the capacity to do a great more number of services, and provide what our community needs. So there should be some sort of attachment included with the Plan, that details what we could do with some additional funds. So thank you for your time today. (Applause).

MICHAEL MEDEMA: Thank you, Alicia.

REBECCA TURNER: I know that we have the challenge of presenting in this gym, with all kinds of echoes and everything. So when people speak, could you speak just a little bit more slowly than you automatically do? And that might help us with hearing and recording. Thank you a lot.

HEIDI HAMILTON: Hi, my name is Heidi Hamilton. Thank you very much for giving me the opportunity to speak. I'm here on behalf of Survivors International, which represents about 20,000 survivors of torture who live in the Bay Area. I'm here because I'm concerned that the Mental Health Service Act Plan in San Francisco County makes no mention of survivors of torture. And survivors of torture are a severely marginalized, unrepresented and vulnerable population, who are in desperate need of mental health services. The organization that I represent, Survivors International, is a 501(c)3 organization based in San Francisco, that provides mental health services, legal services and medical treatment to survivors of torture. We've been doing this for over fifteen years, and have provided direct psychological services to 1800 survivors, from over 93 countries, at minimal cost or for free.

Survivors of torture desperately need your help. They need your support, they need your funding, they have been victimized and traumatized throughout their lives, and have come to the United States seeking shelter and hope for a new life.

I don't want to speak quickly, but I do want to tell you a little bit more about this, and I'm concerned I only have a minute left. So a powerful way to...

MICHAEL MEDEMA: You actually have two minutes, so go right ahead.

HEIDI HAMILTON: Oh, great! Thank you. The most powerful way to demonstrate the need to provide torture survivors with mental health services and MHSA funding – and specifically why survivors need to be recognized as legitimate stakeholders in this process, is through one of the cases – Case RN, one of our clients, who is a 24 year old man from a central African country, whose father worked within a previous government of the republic, which was overthrown by a coup in 2003. Following this coup, Mr. N was imprisoned by supported of the new regime. He was kept naked and alone in a dark for two weeks, and then transferred to a larger cell. He watched executions and tortures of others, including beheadings with knives, and he was made to wrap the bodies of the dead and throw them in a nearby river. He suffers from post traumatic stress disorder and major distressive disorder, with such symptoms as insomnia, avoidance of stimuli, hyper-arousal, and dissociative flash-backs.

Survivors International has been instrumental in providing him the psychological services he needs to lead a healthy and productive and successful life here in San Francisco. And over the entire course of Mr. N's treatment, the County mental health system never got involved.

Although torture survivors squarely fit under the rubric of trauma survivors, it is important to specifically recognize torture survivors as a group, because they have unique needs that differentiate them from the larger group of trauma survivors. If survivors of torture were identified as their own subgroup of trauma survivors, it is more likely that they would get the specialized care that they need.

For example, when a survivor of torture is in the emergency room, complaining of memories of teeth being pulled out with pliers or the like, a doctor who knows that there are many survivors of torture in San Francisco may be in a better position to understand that the patient is experiencing a flashback, as opposed to suffering from hallucination. I'm asking you to specifically recognize survivors of torture as stakeholders in the MHSA process, and thank you very much for giving me the opportunity to speak. (Applause).

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MICHAEL MEDEMA: Thank you. Marilyn, you were next?

MARILYN SHIELDS: Thank you very much for giving me the opportunity to be with you today, and I appreciate the dedication, and hard work that you all have performed during these past months. I'm an older adult. And I see lots of people every day who are really struggling to really survive. So we are, indeed, grateful for the major portion of the Moines being dedicated to the older adult. I'm going to start off by reading the vision statement, and then I'll go into the rest of it.

It is our vision that all members of our community, young and old, who experience behavioral health challenges, should lead happy, productive and fulfilling lives – free of stigma, in a safe and least restrictive environment, and receive relevant and effective services from a comprehensive behavioral health system that is recovery oriented and culturally competent.

In November 2004, the voters of San Francisco passed Proposition 63, MHSA. This resulted, as was mentioned earlier, from a one percent tax imposed on incomes over one million dollars. These funds are for community service and supports. It's a three year plan. San Francisco citizens widely supported this Proposition 63 – 74 percent of the voters voted in favor of it. It was estimated at that time, we would receive 50 million dollars or more funding, due to the rate of high mental illness and homelessness in San Francisco, and we all see this every day. San Francisco's actual allotment was five million dollars for this part of MHSA. This is very far below what the City actually needs to meet its needs.

The major problem is among older adults – focuses on isolation, hospitalization, homelessness, dementia and suicide. These funds are definitely not adequate to care for its citizens. San Francisco will use 51 percent of community service and support funding for full service partnerships. This means that consumers become partners in their recovery plan – whatever it takes to make a difference in housing, relationship, crisis cases, education, and fewer involuntary services.

Now for the breakdown of these funds – the older adults received 652,835 dollars – 180,000 dollars for a senior recovery center for housing, including peer support and outreach. 300,000 dollars for supportive services for housing, including peer case management. 172,835 dollars for mental health services in primary care centers, including dementia behavior management.

To the direct point, older adults, 27 to 34 seniors and adults – those hospitalized in a high care levels, those in adult protection services...

MICHAEL MEDEMA: Marilyn?

MARILYN SHIELDS: ...is that it?

MICHAEL MEDEMA: Yeah, can you wrap that up?

MARILYN SHIELDS: ...the homeless and the monolingual older adults, and those who are isolated. Thank you again for your many hours – let's see if we can do it better next time. Thank you. (Applause).

MICHAEL MEDEMA: Thank you, Marilyn.

JAMES McGHEE: We'd like to have the next three speakers come up. Wing Tse, Michael Smith, and Bridgett Brown.

WING TSE: My name is Wing, I'm the health worker one(?), and a recovery client. The first thing I would like say is the vocational? And the vocational training is very important. I see the report, there's a lot – a portion of money is for the Department of Rehab? And it's very important for the consumer who got the training and back to the work force, and so that they can learn what they have in the training, and also contribute back to the (a few unintelligible syllables), or... or other agency.

And the other thing is, when they get the training, and they can then get hired in the (a few unintelligible syllables), or City and County positions, and... and go into the entry level para-professionals. And also giving back what they learn to the system. And, which is what the Dr. Bob Cabaj has mentioned about training peer counseling and peer support intern. And I think it's very important. And so that the clinician, they can do the high level job functions. And let the peer do, let's say, in

home (?) (sounds like “reset”), socialization, accompanying the client to the Social Security office, apply for newly(?) ID card, or even in the outpatient clinic. And I would say it would benefit to both party. Both consumer can earn some money, and also help the clinician to reduce their workload.

And the second thing I would like to mention is the (?) (sounds like “Wiser Bay Newsletter”). And that is a consumer run newsletter, and... consider I would like if you could consider allocating some continued funding to make this newsletter survive. It's very important, because consumer – I think this only the one consumer newsletter that happen, and exist in the community. And we only get the update news, for example, see pictures, or let's say some of this kind of meetings, training, local training, national conference, and also... this is the sources that can give the... that can give a positive and productive feedback, in order to increase the quality of services for the behavioral health services, to the consumers, family members, and in the community. And it will create a lotta job for the consumer also, by working in only one project, the Wiser Bay. For example, the consumer can work as a editor, photographer, story writer, artist, outreach interviews. And it will include a lot of different color of people in a diverse community.

And third, the last but not least, I would like to say the training – offering the training, for example, in the community. And with... prevention and early intervention is very important. The reason is, the consumer and family member can learn what they should do, and when they see their family member in crisis, and it will really, really reduce – give me fifteen second more!

MICHAEL MEDEMA: Go ahead, Wing, that's fine.

WING TSE: Okay. Greatly reduce the hospitalizations, and also the first episode relapse rate, and in different (several unintelligible syllables), especially minority and even the English speaker. Thank you. (Applause).

MICHAEL MEDEMA: Thank you, Wing.

MICHAEL SMITH: Hello. Thank you to the Board. My name is Michael Smith, I'm here representing the Adolescent Health Working Group. Thank you to the community, as well. We're here today to address the community ownership of youth mental health care. The Children, Youth and Families, and the Transitional Age Youth Subcommittees were extremely outspoken on the need for community based and community validated mental health care for youth. This care needs to be peer designed and run. It needs to bring youth together in a familiar and respectful community setting. Ask them – they know the places – or start with schools, rec centers, faith based organizations. This care needs to validate life experience as equally as clinical experience in providing therapy to youth. And this care needs to use non-stigmatizing language – “mental health services” is not comfortable language for youth.

The community supports and services funding provides a unique opportunity to not only reform the delivery of mental health care to youth by bringing it right to the community's doorstep, but also by re-shaping the community's perception of mental health care. The opportunity is here to provide youth the opportunity to inspire – inspire youth to engage their communities for support during times of crisis, be it violence or unemployment or homelessness. And to celebrate with their communities during times of success, like graduations, employment or unions. This care must be community competent.

We offer the following recommendations, to ensure youth and their families are present throughout the implementation, planning and delivery of CCS funding – be it through full service partnerships or systems developments. And some of these things are going to echo a little bit what the Mental Health Association and a few of the other people have talked about, in terms of community support and consumer involvement.

At the City level – recruit and retain youth groups to continually advise City mental health services about their specific community mental health needs. What are they seeing? And how can they help?

Appoint community mental health liaisons to work with them, and make sure these needs are met quickly and accurately, by using established and respected CBOs – community based organizations – and training them or increasing their funding, or providing clear avenues for additional funding outside of City, State or Federal funds. To provide therapeutic peer groups, reducing the amount of clinical time and care spent on a single youth. Providing vulnerable youth – lesbian, gay, bisexual, transgender youth, homeless and runaway, victims of violence – with a healthy community. Immediately help vulnerable youth to find, or create for them, a positive place to live, work and engage their peers. This is an essential prevention and

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recovery network.

Community supports and services funding must be spent true community level intervention and prevention. Continue to go into the communities and ask them for their help. Thank you. (Applause).

MICHAEL MEDEMA: Thank you, Michael. And Michael, if you have those in writing as well, those points? (Pause). Okay, thank you. (Pause). And this is Bridget Brown, who's a former Mental Health Board member, who we all miss greatly.

BRIDGET BROWN: Yeah. Hi everybody, my name is Bridget Brown, and I work for Independent Living Resource Center here in San Francisco, which is a disability organization. And we had our whole staff read the draft for the Mental Health Services Act, and these are some of the issues that came up – so they're not just my issues, but other people with disabilities who are on our staff, who are working. And they felt that, while there are many good things in the Plan, such as consumer warmlines – and attention was paid to cultural competency in general, there still is the fact that the City of San Francisco is still dealing with a fourteen year old complaint, that its mental health system and substance abuse programs are not physically and programmatically accessible to people with physical and sensory and cognitive disabilities, who have mental health issues in San Francisco.

These populations are almost invisible in their report, and there is no assurance – or we would hope that there would be some assurance in the Mental Health Service Act, that providers be made accountable under the ADA, that the Mental Health Services Act will be accessible to everybody with mental health issues.

We had a person who was visually impaired, who tried to read the charts in the Mental Health Services Act. He uses a reader, and he scans it on the computer, and he couldn't understand what the charts were all about.

Another issue that came up was, there are people in Laguna Honda, and it says something about "it only effected seniors". Well, all ages of adults get sometimes send to Laguna Honda. And they also said that the report used the words "suffer" and "victim" a lot in the report, and we felt that that was disempowering to consumers.

And a recommendation that they had for the Mental Health Services Act, is that maybe they should try to partner with non-mental health communities, especially when it comes to the long term care planning, and long term care – maybe they should part of the Long Term Care Coordinating Council, so that everybody would be on the same page. Okay, thank you. (Applause).

MICHAEL MEDEMA: Bridget, are those comments in writing, as well? (Pause). Have you submitted those?

BRIDGET BROWN: I just scribbled things down, but I do plan to e-mail Helynna about my points. Thank you.

MICHAEL MEDEMA: Thank you, Bridget. Dr. Cabaj? Yes, go ahead. (Pause). Hold on, he's getting you. Go ahead.

BOB CABAJ: I wouldn't do this normally, but Bridget has these great ideas – and one thing, Bridget, just to reassure you – the ADA accessibility of the programs – we didn't mention that in the Plan because there's separate money that we can get from one-times funding. I didn't talk about that, but our goal is to use the separate, one-time funding, to make sure all our programs are fully accessible. Because it's money allowed for capital improvement. So that's why it's not in the plan – just to clarify that.

MICHAEL MEDEMA: And perhaps, Dr. Cabaj, that could be reflected in our Plan in some way, that we do plan to access other things to make those things happen, so that it's not a questions in our plan.

BOB CABAJ: Okay. (Pause).

IDELL WILSON: Hi.

MAN: I was in – I've been in (a few unintelligible words), and I've...

IDELL WILSON: We're gonna get to the next three speakers first, and then we can come – you can talk to... them. Okay, let's get ready for the next three speakers! HOW Y'ALL DOIN' OUT THERE? All right! Yeah! Let's liven this up, come on, let's get it goin', let's START it y'all! Uh-huh! Okay, we got Edward – are you out there? Edward Fong? Michelle... Michelle Moore? And Noah King. Please speak your name first. Thank you.

EDWARD FONG: Ladies and gentlemen, good afternoon. My name is Edward Fong. I've been accessing mental health services for nearly six years for my anxiety disorder. I've been well provided for, and... I'm quite grateful. Many consumers have needs that are unmet. The Behavioral Innovations Task Force was formed, along with the Research Development Associates, and has devised a well thought out draft. All of the people involved should be commended for the fine work. I've been fortunate enough to have participated in the Mental Health Services Act in a peer support role. And so now I'm a staunch believer of vocational rehabilitation. It plays a key part in the wellness and recovery of many mental health consumers.

Members of the Mental Health Board, you are the guiding light, so to speak, for the mental health community. So your approval of this plan will set the wheels turning, into a new dawning for the mental health system. Thank you. (Applause).

IDELL WILSON: Thank you, very much. Michelle Moore, from the Office of Self Help.

MICHELLE MOORE: Hi. Thank you for giving me the opportunity to speak. Unfortunately, I don't have anything prepared, but I have enough courage to speak from my heart about what I feel is necessary for the mental health community. I've been reading some of the ideas that you're going to support for the use of these funds. And I notice you have a section of a drop-in, a crisis drop-in center for a 24/7 warmline. And I just wanted to stress an importance of that type of idea for the community. There's a lot of pressure that's put on the suicide prevention lines. And sometimes people just need to talk. And every time a person calls, they may be put on hold for a... situation that may be a little more... crucial. And sometime the person just needs someone to listen, so I think the 24/7 warmline – it's a very good idea.

The Office of Self Help have – we've had many meetings considering one of our centers to be the foundation of that warmline. And we hope that it can be supported by other representatives of different mental health services.

Also, I wanted to stress that when – we are hiring our consumers, so we can have these positions paid. Not just internships – hopefully paid positions. We want to keep in mind how many – how much of a diverse community we have. So... it's been brought to our attention that – we decided we wanted to get consumers who are bilingual. We already have one employee who is bilingual – she is Filipina – and she has been a great asset to us. We are hoping to also hire someone who is fluent in Spanish as well as English, and hopefully some type of Asian language – maybe Korean or Mandarin. And I feel that that's a very important commodity. Because sometimes when a consumer wants to reach out, they may not have the courage, because the clinician or the service provider may not speak their language. And I think communication is very important, when you decide you WANT to reach out to someone. And if you don't know anything about their culture or their language, how can you help them?

So I just wanted to thank you for listening to me, and hopefully we can work some of those ideas out. Thank you very much. (Applause).

IDELL WILSON: Thank you very much. Okay, Noah King? (Pause). And if you guys – if you're havin' a hard time, if you can't write it out, or you wouldn't like to speak it, you want someone else to speak for you, you can ask us, and we will gladly – I will be your mouth, if y'all don't say nothin'! Okay?? 'Cause it's about YOU – you consumers out there – that you guys speak from your hearts today.

NOAH KING: Hello, my name is Noah King. I have no complaints about the Plan, but I do have a complaint about who it effects. There gonna be some changes in November with Medicare, about prescription drugs, and I think that needs to be sent out. That's all. (Applause).

MICHAEL MEDEMA: Thank you, Noah.

IDELL WILSON: Thank you, Noah.



REBECCA TURNER: Okay. You know, I only have here... two more names, and I just want to take a little... a brief moment to remind you that anybody who has not spoken, and you want to speak, please fill out one of the yellow cards. And if you've already spoken, and you would like to speak again, we've got time – we're here for you. So please feel that you can sign up again, and we'll call you up again. I know some of you maybe didn't feel you had enough time to say what you wanted to say. Rich Snowdon, who's there with the yellow cards – you can feel free to get one from him.

While we're taking just this little break, there's also a few more people in this process that I really feel like we need to thank. One is Pat Bennett, who has worked tirelessly. You know, the State had these very stringent requirements of how you have to write these voluminous reports to get your funding. So without our consultants, RDA, this would've been just an impossible task. So I really appreciate Pat. She's over there...

MICHAEL MEDEMA: Pat, can you raise your hand? (Applause).

REBECCA TURNER: And also, her team. I mean, people also rely on their team to help with this whole process. And then the other person who also has worked tirelessly, is Mike Fleming, who has recorded – he's over here, behind the camera – and he has (chuckles) recorded (applause)... hearings for the Behavioral Health Innovations Task Force. We have just – I don't know how many hours of testimony on tape, which is a really wonderful thing. So...

MICHAEL MEDEMA: And we have more, too.

REBECCA TURNER: One more?

MICHAEL MEDEMA: We also have one more person that we should acknowledge as well, who's been at – well, besides what the – actually, we should probably do two here, but one is someone who's been at every one of our Task Force meetings, sometimes passionately testifying, sometimes sitting in the back observing, but always available for us – that's Officer Art Howard, who's sitting in the back, who's been at every one of our meetings. (Applause). Our official guardian, I guess. And I'm just wondering if the people who are here who were members of the Task Force could just raise their hands – if we could give them a round of applause, as well – the people that sat through hours (applause) of this.

REBECCA TURNER: Okay. And there's other people out there who usually make comment, who aren't saying anything – but I won't mention their names unless they want to make comments.

MICHAEL MEDEMA: (Chuckles).

REBECCA TURNER: Okay. There's three more at this point – LaDonnis Elston, Alex McGowan, and Frank – I'm sure I didn't say this right – Vallecillo?

MICHAEL MEDEMA: LaDonnis?

LaDONNIS ELSTON: Good afternoon. My name is LaDonnis Elston, and I am... Program Manager with the Community Behavioral Health Services. But my area that I work in most is the Bayview, and I'm very familiar with the Bayview area. I want to say that, we had talked to, and many people had hoped to be here today, but I know that many of you are aware of the hundred deaths that have occurred among the youth in this area. As a matter of fact, there was a vigil last night for the young kid who – a baby, pretty much – two years of age, who was killed along with his father, and his mother was shot – on Thursday night. So there are preparations for those funerals. Also, I'm sure that many of you are aware of the mother who allegedly killed her children by dropping them into the bay on last Wednesday.

So the African American community is certainly suffering right now from hearing about, or impacted by, the continual killings among the youth in the Bayview area, primarily. One of the concerns is that many of the youth have really lost hope, and they see no way that they can survive. So they have, unfortunately, turned to things that is not going to help them live for long periods of time.

So I am so pleased to see that there is some effort around the... in the children and youth, where there will be outreach. One of the things that I want to emphasize is that cultural competence is really, really important. I do think that a lot of the youth really, really need to have some modelin' behavior, some support, where they can identify with the individuals who are

providing the services. So I would truly like to emphasize – if anything I could leave here sayin' today – is that I think the services in this area should certainly be increased, and also culturally competent.

The other item that I want to emphasize is the vocational support. Now, that is wonderful. Again, I think a lot of the youth have lost their hope. Many of them have come to me and talked about, "Yeah, we've been trained. But after we are trained, there's no job." Well, I don't want these youth to be promised a job, be trained for a job, and then told "Oh well, there's nothing for you." I mean, I know the economy drives a lot of the jobs. But the reality is, just to not put a person in a training just for, to be in a training. Because that is very discouragin'. And it's, it again, leads to more hopelessness.

So I've seen many of the youth trained in this area, who have been trained to do construction. They come and show me their tool belt that they graduated from the program with. But then at the end, there is no job! So... that doesn't help them – it makes them feel worse! So I encourage that the RFP, when this is done, that the individuals receivin' these funds, be held accountable to their ability to work with these youth, AND to help them get realistic jobs. Don't be promisin' something that there is no hope for.

The other thing I want to applaud is the outreach. I am so thrilled about that. Because – and just finishin' this up – is that many of the families in the Bayview don't have transportation. They are livin' marginally anyway. So to get to places on time, a lot of time, is difficult for them. So if there could be a little more outreach, I think that will serve the community well. Thank you. (Applause).

REBECCA TURNER: Thank you.

MICHAEL MEDEMA: Thank you. And LaDonnis, we're going to have some extra time, so you can come back around and talk some more, if you'd like. 'Cause I can tell you got some more to say. All right? (Chuckles). Alex?

ALEX MCGOWAN: Hi. My name is Alex McGowan. While I do work for the Bayview/Hunter's Point Foundation, my area of focus is a little bit different. My concerns revolve around the mental health services and treatment – the patients in psychiatric wards, psychiatric hospitals, and other clinician settings. One of them is medical procedures and administration of drugs. How can we better improve our medical procedures, before deciding to administer drugs to patients? Can funding be set aside for research for procedures, if they don't exist already? Can we have a procedure to test people's blood level, to see how much they CAN take? How can we better go about the educating people? Educating practitioners and other people, about the drugs that they need, about administering them? And also, lessening the problems associated with the brain-dulling side effects. How do we change medications more effectively, when we need them to be changed?

The fact is that drugs are drugs, and they can create more imbalances, sometimes. Sometimes they will only provide temporary relief to some patients. And in some cases, they can even become addictive. More information about diagnosis, medication, withdrawal, and integration back within the community after being off medication is especially needed, and how it will effect himself, and their families and friends.

Also, living conditions within these hospitals. Consider the experience of life in hospitals, that these patients go through. How can we improve the quality of this?

Volunteers – if there are no family members or friends that these patients have, how can they connect with other people, when they only have, for example, ten minutes' check-in every day with a psychiatrist? There is much isolation going on in these places, for all age groups. Can we implement, perhaps, or fund a volunteer program where we have volunteers who might talk to these people once in awhile, when they need them to? Can they take them out into the world a little bit, a half an hour on the premises for awhile, to be able to connect with the world again? To be able to feel grass or a raindrop on their forehead once in awhile, when they want to?

Finally, independent living services provided afterwards, after discharge. People change as medications change. How can we learn to relate to people better when they go through these changes? How can we talk to them, and how do we know that we're understanding them, and they are understanding us? How can they – we help them learn how to function off medications again, in the real world? Also, this can all be applied to all special populations as well. Thank you. (Applause).

MICHAEL MEDEMA: Thank you.



REBECCA TURNER: Michael's pretty scary, actually.

GEE: Okay (chuckles). Again, my name is Gee(?), and I am representing Asian Women's Shelter. Asian Women's Shelter, we serve battered immigrant Asian women and their children. And there are two specific direct service area. One is to serve women who are escaping domestic violence. And the other one is, we also serve survivor of human trafficking. And at Asian Women's Shelter, we commit to serve women who are different – who speak different Asian languages, and also experience – come from different cultural background.

My job is to hire and train, recruit women from different Asian communities to become bicultural, bilingual advocate at Asian Women's Shelter. We provide peer-to-peer support at the shelter. But when it comes to access to mental health services, we experience that it is very, very hard for our client to access to mental health services. So I'm gonna talk specifically about two things – one is language accessibility, and the second is cultural accessibility.

When my client, for example, a Cambodian speaking woman who is a survivor of human trafficking, needs to access to the service that is culturally and language appropriate for her. It is very, very hard. And oftentimes, I experience that I would have to provide an interpreter to accompany to a mental health services, to provide an interpretation – which work sometime, but not all the time.

At Asian Women's Shelter currently, we have access to 27 Asian languages, we have on call, of language advocate. So I would like to encourage the Board to remember the marginalized group, and increase the language accessibility, as well as cultural accessibility, to ensure service to all populations. Thank you. (Applause).

MICHAEL MEDEMA: Thank you very much.

REBECCA TURNER: Is there any other member of the public who has wanted to speak, and who hasn't yet done so? Or anybody who wants to come again?

MICHAEL MEDEMA: LaDonnis, this is your chance. (Pause). (Chuckles). (Pause). (Chuckles). (Pause).

REBECCA TURNER: If the Deputy Director of Behavioral Health loans you his glasses for this (chuckles)...

LaDONNIS ELSTON: Loaned me his – isn't that cooperation? My goodness! Anyway, the only other thing I really, really wanted to add was that... the supported housing? I think that in the Bayview in particular, we have so many families that are at risk in... because a lot of the family members who might would step in to support the individual who has the mental illness is also marginal – they have to go to work, they don't have time to be takin' care, or bein' in support of the other family members, like the younger children. I think it would be helpful to have what we call, like a safe house in the Bayview. We actually talked about TWO of them – whereby an individual – we was talkin' about, like the lady who dropped her kids into the bay – maybe someone would have seen something. And I'm not sayin' that that's the situation – I'm just sayin', this is an example where I think that a safe house would be helpful. Because the individuals might say "Okay well, let's take the kids over to the safe house." There would be staff there, who would be able to assess, and to work with the families, to help them get the support they need, or to provide the support for the families. And I think in the Bayview, there is not such a place. And I think that would certainly help a lot of these young kids who are – often have parents who are young kids – you know, sixteen and seventeen years of age. So I certainly hope that in the supportive housing situation, that we would be able to at least develop something along those lines, where there could be some support for that type of a situation.

And... given the fact that a lot of the gun violence have occurred in this again, I do the outreach – again, I want to emphasize that I think that is a great, great opportunity to – 'cause many of these individuals are not gonna come to our mental health center. So we're gonna have to have people who are competent, and who are willin' to go out and outreach to these individuals, and establish relationships with them. So again, thank you for the opportunity to put that in. Okay. (Applause).

REBECCA TURNER: For people who've just arrived, and maybe haven't had an opportunity to sign up – do you want to make a public comment?

MICHAEL MEDEMA: Is that nodding of your head a yes, that...

REBECCA TURNER: Is that a yes? (Pause). Okay.

MICHAEL MEDEMA: Okay. Do any of our Task Force – Pam? (Pause).

PAM FISCHER: I have already today submitted in writing, comments.

MICHAEL MEDEMA: Can you tell us your name, and...

PAM FISCHER: Oh, I'm sorry. I'm Pam Fischer, I'm the President of NAMI – that's the National Alliance on the Mentally Ill – in San Francisco. I was a Task Force member, Chair of the Family Subcommittee. My Co-Chair, Carol Lamont, and I, were really quite disappointed that we saw very little mention of the family in the Plan. In fact, in the adult section, there is not a single mention of family. The family is, in fact, the continuing support and care and love that... mentally ill individuals have helping them. They're there as support. They need to part of the treatment plan. They need to be not excluded by the confidentiality laws. There are ways to listen to family members, and accept their history, and their information that they have to give. And they certainly have information that will be useful, and should be part of the treatment plan.

Another issue that concerns us is that, the fact that an individual has private insurance should not be an exclusionary factor, for them to access City services. So these have been put in writing and submitted, but I thought I might as well add them to the record today. Thank you. (Applause).

MICHAEL MEDEMA: Thank you, Pam.

REBECCA TURNER: I'd like to ask Gladys So? Or Soy? Okay – when you come up, you can say your name. Again, Gladys is with the Mission Council.

GLADYS SOTO: Hi. I just got here, so I don't really know what is going on, but I just want to take the chance to speak a little bit. My name is Gladys Soto, and thank you for allowing me to talk briefly. I came with my daughter and my kids. I want to be part of this. I work at Mission Council, and we provide – maybe we are one of the biggest – without making a mistake – the biggest program for substance abuse services especially for the Latino. And little by little, we're becoming a Latino program. This is Mission Council on Alcohol Abuse for the Spanish Speaking. But since the Mission area has kind of changed, because of the economy and what-, all the stuff that we know about it – we found ourselves providing services for everybody in the community. So I believe that Mission Council on Alcohol Abuse for the Spanish Speaking is becoming a very unique program, because we providing substance abuse services through the Latino perspective, to everybody in the community.

But I was... thinking about my role when I'm here today? It's gonna be money for mental health, and... I mean, programs. And we are working with Mission Mental Health, coordinating services. But our fear is that, if mental health becomes so big, you know, some of the small programs that are providing good quality services for the community are gonna probably disappear or merge. And so I just came here to make sure that whenever you give your budget, your money, you don't forget about Mission Council. In case there is any – oh, the substance abuse programs in general – but since I work at Mission Council, my concern is like, most of the substance abuse programs HAVE mental health. Some – the biggest ones. We don't have any services. And we are becoming strong as a community. And we are willing to offer service to everybody. And we are very diverse, for real, with the heart. And just don't forget about us – that's what I wanted to say. Thank you. (Applause).

WOMAN: Thank you.

MICHAEL MEDEMA: Thank you, Gladys.

REBECCA TURNER: Okay. There's still time for others to speak – still plenty of time. I want to just move now – and so in case anybody is THINKING about saying something, please... please know that you have another opportunity.

You know, the next – one of the next steps to happen, once this plan goes to the State, is that there will be proposals sought, for – by community based organizations. And I wondered if, Bob Cabaj, if you might say a few words about next steps in that

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direction, to inform people?

BOB CABAJ: We can... (pause)... our... our excellent multi-media person there, thank you very much for... yes, the next steps, actually, is good to focus on. Cause people are not always sure what happens, once this plan goes forward. What we intend to do, is hope that we incorporate these comments, and makes the Plan acceptable on the State level. The State tells us they need three months to plan, and review the Plan – meaning that if we get it to them by November 1, it would be February 1 before the Plan would be approved. And that's, again, being a little optimistic, knowing how the State can function. But we do hope that the Moines that we could use for clinical services would be available starting February 1.

We recognize that, if we're starting brand new programs, like a peer center and so on, it will certainly take some time to get up and running. So we don't assume any brand new clinical services could begin in that first month. It's possible – especially full service partnership programs could already be operating, and add more clients to that work. So we are hoping that we'll have at least three months of good clinical programs for this, and then the full year for the next two years.

The money that wouldn't be there, because it's waiting for the time of the Plan to be accepted – meaning money that's already started accumulating in the State coffers as of July, until the day that the Plan is available – could also come to us, but that would be the one-time money, which would be used, potentially, to help make buildings safe and ADA acceptable, to look at staffing patterns, maybe even buying buildings that could be used for peer centers, and so on.

Now, between now and the time that the Plan is submitted, and the time the Plan is accepted, we will start working on what the City calls an "RFP process" – and that's a Request For Proposals. What we will do is, start writing up official requests, using the dollars that we hope to get, to create the programs that are outlined in the Plan, such as say, the 200,000 dollars for supported housing, the money for the peer run center.

So we would put out a, what's called an RFP, for the public. And anyone who's a qualified, County authorized applicant, can do that. And that's most of the community based organizations in San Francisco. And they could, therefore, apply to see if they could provide that service for us.

The goal is that the vast majority of the money be provided to community based organizations to provide the care. There may be some money that would go to the Public Health system, the Civil Service side. And we're thinking programs like crisis services, or 24 hour services that are maintained by the County now, might be enhanced or sustained within the County – but the vast majority of the money should be going to community based organizations, to either create and build, and then continue to operate the programs that are outlined in the Plan.

REBECCA TURNER: Do you know when the Department is gonna ask for proposals? And how can people find out specifically what they are?

BOB CABAJ: Well, we can't release it until the Plan is approved. Because potentially, the State could come by and tell us some of the things we're proposing, they won't agree to. They might say "Well, that's a nice idea," but it doesn't, in their interpretation, fit the goals of the Mental Health Services Act. We believe everything we've ranked and written up is acceptable to the State, but we just don't know. They have the authority to say no to parts of the Plan, or even to the entire Plan. What they've told us they will do is, they will invite us in – hopefully it will include me and a panel of people – who can come and discuss the issues that they might have. And then they will be doing a review panel, which will include consumers, family members, culturally sensitive input. And I believe it'll be about ten people that will actually review our Plan. And then we hope it will be released. I think we can put out the RFP ahead of time, but we can't award any money until we actually get it, because we would have to determine, again, if the State will allow us to move in those directions. My guess is, we will work on the write-up of the RFP for the next month, maybe even a little tighter. We want to get that written, and to be as clear and as simple as possible, so people will know what we're really trying to create in San Francisco, and get that out. And therefore, have a chance for people to start bidding.

Again, since the award money can't be given out till, probably at least February 1, my bet is we will be looking at a review process that will be in the early part of the year. So the deadlines will be a little clearer within about two more weeks, when I work with the Contract Planning Office.

REBECCA TURNER: Thank you so much for asking all these questions – I mean, for answering (chuckles) all these

questions! (Laughs). And one other that I wanted to ask, also, was about – since a lot of people here have been involved in the Task Force, and a lot of people have attended meetings, any thoughts about the length and the process of the Task Force in the future?

BOB CABAJ: The – I think San Francisco's had just the most exciting and dynamic way of planning, and getting involved with this whole implementation of the Mental Health Services Act. Again, our county was the lead. And I think we also led in the number of meetings, the number of people involved, and the length of time involved. Michael Medema next to you, and I, were just down in Burlingame yesterday, discussing how we were doing our planning process. And we met with our sister county, Monterey – and we heard from several other counties. And I believe ours was one of the most extensive. The length of time – in a sense, you can never do too much planning. And I made the joke that I... San Francisco has so many opinions, that it's 780,000 people with 780,000 opinions. And I think we heard every one of them. It feels like it was a long and lengthy process, which is great. Now, how do you distill all of that was the challenge, and I do believe the Plan, as I said, answers the questions the State answers(?), and tries to capture the full breadth of all that we did.

I think the Task Force meetings were long. Many people felt very exhausted by the process. But everyone I've spoke to said it was a FUN exhaustion – meaning they heard – we really HOPE that our presence in the communities – recognize that we want direct feedback from the communities in the future.

The – just as a, kind of an awareness – this is just part one of four, five OTHER plans that are gonna be done. So in other words, all of this Task Force work was just on the clinical service money. We, we're going to be doing OTHER plans, as soon as the State gives us guidelines – about early intervention, about innovations, and so on.

The future of the Task Force – my suspicion is, it will be transformed a bit into a slightly group, since 42 people are a large group to work with – to help with the oversight and the ongoing review of the implementation of the Plan. So it will – there still will be a future, I think, in a modified Task Force. I'm not sure if that answers your question completely, but... we did a lot of work, and I think it's been great.

MICHAEL MEDEMA: And do you see – Dr. Cabaj, do you see the Mental Health Board as having review of plans in the future as well? And sort of, what do you see as OUR role in the future, with the Department and the plans, and the State, and the bureaucracy, and the... (pause)... and I know yesterday, one of the things that was commented on, is... like you say, this is section one or four or five sections. Will each of those require a 700 page plan?

BOB CABAJ: WE HOPE NOT (chuckles). We, we've... many times said to the State, "PLEASE, make the next phase simpler." I think we've all learned from this – this is an elaborate, detailed process. A lot of us have disagreements and conflicts about the – the data they gave us, the structure they gave us. They did do a lot of stakeholder input – "they" being the Department of Mental Health – but I think one thing we've all been urging, at least from the county level, is "Make it simple!" We said the number one complain we've heard from everybody is, "No one can read this Plan, or make any sense of it." That's why the executive summaries were so important. And the Plan, unfortunately, is what they wanted us to submit! So it had to answer all the questions.

I know one critique is, we've got a bad prevalence set of data in the Plan. Well, the State GAVE us some bad prevalence data. So you're right – we can make it clear that we didn't agree with, and don't like the prevalence data, but you know, they forced us to work within certain parameters. So I'm not sure how complex the future plans will be.

Now, I believe the Mental Health Services Act says the Mental Health Board has a role. I don't think it said "just in the clinical services" – so I suspect the other four or five plans, you will be as actively involved as you have been. And I LIKE that. I have learned a lot from you this year, and I'm glad you've been welcoming me in, and letting me even stay when I'm not supposed to be there, or at least – I mean, not technically speaking – 'cause I just love workin' with you all. And this Board, I think, is going to be crucial in the future review of how the Plan actually is used, and the transformation of our system.

We will be having a very important evaluation component to this. 'Cause obviously, we need to know if the new services are working, and if they're trying to – if they're actually making the impact we hope. So we will have a thorough evaluation, and I hope you will also be part of the group that's asking for accountability, and evaluation of what happens.

REBECCA TURNER: Well, when we partner together, even when we have different points of view, I think everybody wins. And that's been the intention, through the process.

And for the RFP that you mentioned – RFPs that come out – I'm sure they'll be on the web site. How are people who are really kind of waiting, and really thinking about this – how can they best, most quickly get knowledge of it?

BOB CABAJ: The – all the RFPs, or Requests For Services, are done through our centralized Contractors Office. And I believe what they do is, they send a letter to everybody that is registered with their office – meaning all prior awardees of services, all prior applicants of services – and then they do post it on a web site. It can be a little hard to reach out to totally brand new systems or programs that have never worked with the City, but that's why general announcements are made, and the information is available.

If an organization has not been certified – I think that's the word they use – with the City, to be a provider, it's... a not simple, but not complex (chuckles) process. Nothing in the City is TOO simple, as you know. But it would be – there would be sufficient time to apply to be a certified provider, and also, therefore, be able to apply for the actual dollars in the Act. So again, the Department of Public Health web site eventually will have that material. And we will work with the Contracts Office to make sure the information is promoted as widely as possible.

I would want us to consider using the network we have used, and developed for this Act, including the work the Mental Health Association has done, and you, to make outreach. Maybe we can find a way to get the information through those same avenues.

REBECCA TURNER: Okay. And any time you have questions, you can always feel free to call the Mental Health Board, and we'll get you to where you need to go.

I'm gonna ask, also, our Board members, if any of them have anything that (:01 recording gap) – people can individually take up to three minutes. They may take less, they may decide to pass at this point. But this Board has worked really hard in the past year, to network with the people that we needed to meet with, to attend meetings, many, many meetings. And I REALLY appreciate my colleagues on the Board, for all they've done and contributed.

I also appreciate the public. Your comments, your willingness to come forward with your own thoughts, your own experiences – and that's not always easy to do. And it's not always easy to do it in a way that it gets recorded live, in front of everybody. So it is really, deeply appreciated, that we've had this kind of community process.

MICHAEL MEDEMA: On a Saturday.

REBECCA TURNER: On a Saturday, too!

MICHAEL MEDEMA: A nice, SUNNY Saturday. (Chuckles).

REBECCA TURNER: We're so appreciative that you're here today. So Board members, why don't we start at this end? And so we're gonna – we're under exactly the same timeline as everybody is – three minutes or less. (Pause).

MAN: I wanted to say that I agree. I think it was LaDonnis...

MICHAEL MEDEMA: And again, can you just state your name, even though...

BENITO CASADOS: Oh. My name's Benito Casados, and I'm the consumer rep, I'm a consumer representative. And I wanted to state that families need to be more included. The Bayview area needs, needs to be considered in this as a high priority for violence, especially for our youth. Also, the fact that we, as a community, need to consider the families, you know, that are out there, that are involved in the violence, and how to best support them. Because in order for... the mentally ill to recover, we have to consider... the family and, as a whole. Because when you have a mentally ill person in your family, the whole family is impacted. And we, as a society, need to consider that. And we, when making this Plan, which I found was very much missing, was the family itself.



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WOMAN: Thank you.

CLAUDIA LEBISH: My name is Claudia Lebish(?), and I'm a consumer representative on the Board. First of all, I want to thank all of you, for your very well thought out opinions, and ideas on where the funding should go, for Prop 63. After listening to all them, what really popped out at me was the need for more family member services – to get them involved in the process, to educate them. 'Cause while the mentally ill person is trapped in a cage... sometimes the family members are, as well. And that can just be – that can be just as difficult for them as the mentally ill person.

And I'm also really impressed by hearing about the need – there seems to be a great need – for both vocational training, and more youth outreach services. So thank you all for coming.

MICHAEL MEDEMA: Thank you!

KATE WALKER: I'm Kate Walker. I'm a... consumer member of the Board. Michael... you spoke to me – I understood you, I think – in saying that we need to take advantage of people who have, who ARE consumers. A consumer will have information that non-consumers can't have. There's much discussion, much... fermentation of... for the past couple of years, about wellness and recovery... which includes consumers. The idea that consumers need to do as much for themselves as they can. They can't... (pause)... can't count on other people to help what other people don't understand. And hooray for the wellness and recovery movement!

I think there is a lot of stuff that consumers can give to each other, that professionals who have never been consumers, can't understand. What... (pause)... the problem that seems forefront to me, is that people who are consumers can give a point of view, and a help, that the professionals not always understand... and appreciate. Sometimes we're right! Thank you very much.

MICHAEL MEDEMA: Thank you, Kate. (Pause).

LISA WILLIAMS: Hi, my name is Lisa Williams, and I'm a family – I hold a family seat. Again, I want to thank you for coming out. As bein' in the family seat, and experienced it as a family member, I think it's extremely important. But I also think showin' up, and breakin' the silence of mental health – it's what the community does. So I encourage you to continue to do that, and to hold us accountable, and talk to your friends and family about mental health in a way that people understand it. A lot of times, the way – you know, professional use of language – people in the community, and friends and family, they don't really, don't understand exactly what it is. So continue to show up. Thank you.

JAGRUTI SHUKLA: I also wanted to thank everybody for coming. My name is Jagruti Shukla. And even in this small group, I'm so impressed by the diversity in everyone's points of view, in the group that did come here. I sit here as a family member, but I also happen to provide mental health services as a physician. And two things that I heard here that struck me – one was the importance of peer support. I think there's only so much in a clinical setting that clinicians can do. And there's lack of training, lack of timing, lack of understanding, often, that occurs. And I... can't... understand why more emphasis has not been placed on peer training.

The second point is, pertains to the actual Plan. One thing that I noted was in the measuring process – I also heard from you – there wasn't as much accountability as I would have liked to've seen, in terms of actually... measuring outcomes. I think to list... as a goal, providing services that foster wellness in recovery is important, but I think it would be nice to see more concrete, quantifiable goals listed, so that we can re-evaluate on an annual basis, and see if these changes are actually working.

MICHAEL MEDEMA: Idell?

IDELL WILSON: Thank you. Hi, everyone! My name is Idell Wilson. I sit as a Board member, and a participant of Prop 63, as a Task Force. And I've been on THAT side all the time, so I came over HERE! I just had to feel the part over here, of all you consumers, who came out to ALL THOSE MEETINGS? You guys used your voice in a process that was so crucial. I would just like to say, as a consumer, as a Board member, as a Task Force member, and as a citizen, AND as a person who lives in San Francisco – thank you, consumers. You guys finally spoke! And I believe they're HEARING you! They – I can hones- (pause because of loud banging noise), I can honestly say we get interrupted, but (laughs) we hearing you guys! And

you guys, lemme tell you somethin' – when you're a consumer, you have to use your voice. If you don't use your voice, how would the other side know? How would they know the services we need? How would they know anything that can do for us? We have to USE OUR VOICE. As they said in the beginning of this process, "Nothing about us, without us." Let's make 'em hold for it! "Nothing about us without us!" Consumers, you've done your job. Thank you very much. (Applause).

MICHAEL MEDEMA: And once again, I get to follow Idell. (Chuckles) It's never a fun task (laughter). My name is Michael Medema. I served on the Task Force, I was a Co-Chair of the Older Adult Subcommittee. I sat with... Dr. Redmond and others on a Data Committee, which was probably the MOST fun on the committee that any person could have... and... we reviewed position papers, we did the whole thing. I think that... I'd like to thank so many people. I know that many of us feel that – well – at least from the male perspective, being involved in this, this is probably as close to giving birth as I will ever get a chance to have. And we birthed 700 pages. Because what you see here is the draft Plan. What you don't see is the 500-plus pages of addendum and appendices and data, and everything that has to go along with this, which I know Dr. Cabaj and Edwin have been reading diligently, right before they go to bed. (Pause).

This is not a perfect Plan. There is no such creature as perfect plan, and this will never be The Perfect Plan. I don't think that any of us are going to jump up and down for joy. This process started... with our... in my opinion, wonderful Mayor, announcing that this was going to be 40 million dollars, and it was going to go for housing. And now we're down to five million dollars, and we're trying to parse it out to every possible group. The key to this – and I think the key that we, as consumers and family members and community organizations, and Task Force members and Mental Health Board members – the key that we want to hold the Department to is the fact that, throughout the process, they have said "This is a beginning of a ten year plan."

There is much that the Task Force members heard, and witnessed, and listened to, that is nowhere in this Plan, because it CAN'T be. We can't put everything into a five million dollar Plan. But that data exists, those proposals exist. They need to be incorporated into the Department's plan for the next ten years, and we need to witness and watch, very carefully, that those things are incorporated.

It's OUR job to go forth with this 500 pages, and educate the people that are going to be using this Plan. That's the biggest part of this, is educating the public now. And educating them continually, about the things that we know need to be incorporated into future plans. We all know what is NOT in this Plan, and that's what we need to see in the future.

I think this is a great beginning. It's a great start. ANY amount of money coming to the City, and ANY change of proposals, and anything that's gonna be measurable and quantifiable, is a great start. I look forward to working with the Department on this, and seeing that these things are implemented. I also look forward to a year, five years, and ten years from now, saying "What else?" Thank you. (Applause).

REBECCA TURNER: You know, my great pleasure of the year was to watch Michael time himself. (Chuckling from the group). And he went right down to one second left, and he said "Thank you." (Chuckles).

You know, it has been really... my honor to be a part of the Task Force, the Behavioral Health Innovations Task Force. I feel that I learned so much from all the testimony, and I was very moved by it. It was just – it was a tremendous amount of public interest and public involvement, so that was very heartening to see.

People say that where you sit depends on where you stand – and I think because of some of my history, I have certain things that I've really been focused on. And a couple of people have said them before me, so I just want to underline those. One is what Pam Fischer said, about the inclusion of family members to the extent possible. Because I just know from some of the work I've done, in psychological and mental health research, that involvement of family members can make a huge amount of difference, in terms of decreasing the number of hospitalizations. There is just so much data to support working with the whole system that the person lives in, to the extent possible. And the family is the immediate. So when that's possible, I think that's a really, a very smart way to go.

And also, what Djerguti said about outcomes. As somebody who's been involved in research, it's really important to have as specific outcomes as you can, because that's how you hold yourself accountable.

As an educator, I'm also very much looking forward to the next phase of the planning process that's moving forward –



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education and training. So... my time's not up, but I'll stop.

JAMES MCGHEE: James McGee, I'm a public interest member of the Board. I just want to kind of echo a few things. And one is, I believe in public involvement, and I really, truly appreciate you coming out this Saturday morning, and giving us your views. Because it is extremely important for us to know that. I also believe in accountability. And I don't think any plan or program can really be true work, without the accountability of the community. So I would truly tell you to be involved in making sure that the money is appropriate {sic}, that the programs and organizations that receive the funding are held accountable for doing their mission in helping the mental health community.

Your voice is extremely important. And a lot of times, I think the community does not get involved at the level that they should. And I would just encourage you, as this process continues, that you stay involved. Its success is based on your involvement, and I cannot overemphasize that more. So if you – I think the lady left earlier, that said that she just heard about this public hearing today. We are going, again, to have a public hearing at City Hall on Monday, from 4:00 o'clock to 7:00. If there are other people in the community that you know, that would like to participate, or didn't get a chance because they heard about this too late, please encourage them to come down to City Hall this coming Monday, on October 24<sup>th</sup>, from 4:00 to 7:00 o'clock in the Supervisor chambers. We will be there, listening to your comments and your concerns. Thank you.

TOM PURVIS: I'm Tom Purvis, and I'm family member of the Board. I have several comments I want to make. First, I'd certainly like to echo what Pam Fischer and others have said today, about the importance of families being represented in the Plan, and everything we do. It's absolutely essential that that take place.

Second, there's another issue which is a perennial issue, and that is, how do we get services to people who are treatment resistant? I'm saying that because in just the past week, I had Kelly Dunn – Caroline Kaufman who's head of the Mental Health Crisis Team, and a woman named Kelly Dunn, with the San Francisco Police Department, who is very, a very able representative for mental health, spent three hours at my house, trying to persuade my wife to come in for treatment. And although my wife was clearly psychotic, she wasn't, quote, "a danger to self or others," or gravely disabled under the very narrow provisions of 51-50. I realize that's not exactly a funding issue, but it's an issue we need to grapple with somehow.

The other thing I want to represent is another hat I wear, and that's for an organization called Ascend, which represents people, actually adults, with autism and Asperger's Syndrome. We were pleased, representing that organization, to see that children with autism are given a fairly high priority in the Plan. But we would also like to see the Plan reflect the needs of adults – all these children become adults, and their needs don't stop when they leave school. They continue on into adults. And we'd like to see the Plan reflect that more. We have submitted written comments concerning that issue. That's what I would like to add. Thank you.

MICHAEL MEDEMA: Go ahead, Lavonne, try it.

LAVAUGHN: Good afternoon. Can you hear me? First, I'd like just to start with givin' ourselves a hand clap. (Applause). And that's because we're here, sitting in this room today. And I know everybody had to make some sacrifices to do that. In listening – and I am a family member – I serve on this Board – I'm pleased to do so – there's a lot of information, there's a lot of caring people on this Board. I also serve as a member of NAMI, and that too, is very, very helpful to me, being a family member.

And I can't stress enough how important it is that family is included. It is CRUCIAL. I don't think that... without family being in that individual's life, the same amount of love – I'm not sayin' that people with professional backgrounds can't help a lot, but nothing is like family.

The other thing I'd like to bring out is, I was listenin' to Dr. LaDonnis when she talked about jobs – training – but where are the jobs? That is another very – almost could be put in the same category as post-traumatic stress. You get really happy, you got a certificate – now where is your gainful employment? We need to stop makin' promises and not following through. (Loud electronic noise) Point well taken! The other one is...

WOMAN: LaVaughn, that was a bit much. (Loud electronic noise again). Sorry about that.

MICHAEL MEDEMA: Go ahead, Lavonne?

LAVAUGHN: Okay, the other one is cultural competence. I think it's imperative, because in this southeast community, a lot of time – and families, African American families and others too, but I'm speakin' to this from knowledge – you want to keep mental illness QUIET. You don't want to TALK about it. We NEED to talk about it. It's the SECRETS that kill us. We need to get it up, we need to get it out.

The other thing that I'd like to say to each of you is, "Miracles happen when someone cares." And I want to say, as you all know, "It takes a whole village to raise a child." And we are, today, that village. So again, thank you very much for being out here. (Applause).

JAMES SHEA KEYES: Good afternoon. I'd like to thank everyone who showed up today, and of course to all of you for staying, till the very end. My name is James Shea Keyes, and I am the appointee of Supervisor Chris Daly. I sit on the Board for public interest. Now, while I am new to the Board, I'm not new to mental health. What I'd like to say is that I do have some concerns, regarding... this Plan that we have before us.

I work as a volunteer in Supervisor Daly's office. And the job that I do for him is constituent concerns. That means when anyone in District 6, or in San Francisco, calls that office and they have a problem, I handle it. Yet, for some issues, such that I've needed to have one of our outreach teams go out and work in certain areas, I don't believe that I've gotten the type of response that I would have liked, nor have I seen the results that I feel should have been – well – done, from these agencies. So my concern is, in putting money into existing programs, whether(?) they decide that they need to have new, stepped up programs, and have that money added on to them – I'm very concerned about that.

What I DO see, is that having clients, consumers of mental health, and their families, take on some of these positions and get that money, go out and do these jobs, and show that they CAN, and WILL make that difference – this will de-mystify mental health for people. This will give greater self expression and self worth to the people doing the job. This will take off a lot of work from our already overworked police department, hospitals, and other services that we have. So I am a very loud on this Board – a new voice, but a loud voice – for client advocacy. And I will make sure, using my seat here on the Board, and also in speaking with the other Supervisors, that that is a component. And if it's not a component, and a strong component, I might have to say that we need to take this Plan, and have it re-tooled, before submitting it to the State of California. Thank you. (Applause).

TOYE MOSES: My name is Toye Moses, and... I want to take this opportunity to thank everybody, most especially the staff and the Task Force, for the wonderful job they have done. Also, I want to thank my colleagues. I've been on this Board, I guess, longer – and I guess I can compare the Mental Health Board of today with Mental Health Board of yesteryears. This Mental Health Board of today, they're really doing a wonderful job. They really – they're so dedicated. And I'm so proud to be part of the new one.

I totally agreed with Dr. LaDonnis, concerning the outreach more to this neighborhood, and also the safe house she was talking about. I hope this – the train has not left the station – this is very important suggestion that she came out with. And I just hope Dr. Cabaj, you would take note of that – it's very important.

Also too, in your findings – I didn't hear much about the grandparents, who are so dedicated. They are considered caregiver in this neighborhood. And they spend most of their small income taking care of the grandchildren. And... I hope there could be some compensation for them, so that they will continue to provide services to the children. They are consider great, great caregivers. And I hope you will remember that. I just didn't see much of that, in your talk. So please, Dr. Cabaj, don't forget – it's very important.

Again, thank colleagues, and thank you, the Task Force members. (Applause).

REBECCA TURNER: Okay, there's one more person. One more person who said she wanted to speak? I saw a hand, but... (pause)... okay. Annemarie?

ANNAMARIE HEWSON: I wanted to know about the comprehensive Work Plan that is being written, to operationalize the information submitted to the State.

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REBECCA TURNER: Annemarie, could you start over?

ANNAMARIE HEWSON: When will that be ready, the Work Plan? Was it you, Dr. Cabaj, was talking about? You were talking the comprehensive Work Plan, which is in the summary here? The comprehensive Work Plan that is being written to operationalize the information submitted to the State – when will that be ready? Is it...

BOB CABAJ: That IS the attachment to the – that is the Plan. It's...

ANNAMARIE HEWSON: Besides, besides the draft Plan, there is another...

BOB CABAJ: No. To be clear, the Work Plan is what the – is in that printed material. It's the appendices right after all the data. I think it begins with Appendix 1 – I may not have that right – but it's, the Work Plan is what describes what we hope to do with each age group. It's in the printed, 200 page material.

ANNAMARIE HEWSON: I see. So it's the same as the draft Plan.

BOB CABAJ: Right.

ANNAMARIE HEWSON: And then I wanted to know why some position papers were not summarized in the Proposition 63 web site. (Pause). Some positions paper only were summarized... but not all of them. Many of them were skipped. Did you happen to see that? There is a summary of the position papers, but only of some position papers.

REBECCA TURNER: You know, it's possible that... I know one of the primary authors of the report just went out of the room for a moment. When she comes back, she might have that answer. And... what we're gonna do next is take a ten minute break, 'cause I know some people are sitting here, wanting to leave. So when we – during the break, you can ask her. I will identify her, and hopefully I can get that answer for you. Is there anything else?

ANNAMARIE HEWSON: Okay. Yes, there is. I wanted to know, the medications (a few unintelligible syllables) treatment – treatment was mentioned a few times in the draft Plan, but never there was any information about what treatment is. And that is a very, very important thing to include, an essential thing to include. (Pause). And... treatment is the medications, right? That is considered treatment. And the psychotherapy, that is considered treatment. And then something that we, also that the Plan doesn't talk about, is continuity of care, which is extremely important also. Because the way the system is now, it has no continuity of care. Or no file of the client that follows the client to the hospitals where the client goes. And this has happened many times, not only to my son, but to many other people – I know that.

And also the – a regulation about the medications. How – since you are the only doctor here, Dr. Cabaj (chuckles), please, we have to ask you – how do you feel about medication regulations, about the amount of medication given?

REBECCA TURNER: I just want to say, this is – you know, it's not really a question/answer period, overall. It is a hearing for public comment. If you want to add something about that, Dr. Cabaj, that's fine...

ANNAMARIE HEWSON: That is a public comment.

REBECCA TURNER: ...you're often (chuckles) very accommodating to us, but you know, it's... it's really above and beyond the call of duty.

BOB CABAJ: Okay. I'll just say very quickly, that the – all the clinical services will be used – follow evidence based practices.

ANNAMARIE HEWSON: And we also, by the way, also, we don't know what the evidence is, because that is not written in the draft Plan, what the evidence is.

REBECCA TURNER: Thank you. Your point is – I agree with your point. It's not fully spelled out. But thank you very much. The Board is going to take a ten minute break, and we will reconvene back, if anybody has any more public comments that you'd like to make. And in case people are going to be, some people are going to be leaving, thank you very much,

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VERY, very much, for coming today.

REBECCA TURNER: Okay, we'd like to reconvene, Mental Health Board members. (Pause). Okay, I wanted to offer – Annemarie, you had a very specific question. And I just wanted to let you know, I checked up on that. And this is a draft plan – and I have to highlight “draft” – meaning that what you've read, it's just not been completed yet, in the appendix. All of the position papers will be included with a report to the State. So they're all gonna go. And you've just seen something that's in process.

MAN: All the position papers were just put on disk on Friday. Finished, completed, to be put on disk on Friday.

REBECCA TURNER: Would you say that in the microphone?

MAN: I spoke to Carolyn Lieber, and all the position papers had just been completed onto disk as of Friday. (Pause).

REBECCA TURNER: Okay. My question is, is there anybody else who would like to contribute any more comments to the hearing? Yes? Could you come to the microphone? And...

REBECCA TURNER: (A few seconds of unintelligibly distant speech)...

REBECCA TURNER: Okay. Would you like it to be recorded? If you want it...

WOMAN: I don't care what (several unintelligibly distant words)...

REBECCA TURNER: Okay.

WOMAN: ...(2:10 of unintelligibly distant speech)...

REBECCA TURNER: Okay, I'm gonna have to interrupt. But just – let's finish up your thought...

WOMAN: (:43 of unintelligibly distant speech)...

MICHAEL MEDEMA: Ma'am? Ma'am? You know, we gave everybody three minutes... ma'am?

WOMAN: (1:18 of unintelligibly distant speech).

MICHAEL MEDEMA: Thank you very much. (Applause). Is there anyone else that would like to utilize three minutes of public comment? (Pause).

MICHELLE MOORE: For the – can you hear me? Yeah. For the record, I apologize for not introducin' myself earlier, with the first opportunity to speak. But for the record, my name is Michelle Moore, and I'm with Office of Self Help. And I just wanted to share that – I became a consumer when I was fourteen. And... I felt very – well, for the lack of a better term, “consumed,” because I didn't really know if there was any support for me. My family didn't actually understand what was goin' on with me, so I felt pretty much alone. And when I was old enough to understand what was goin' on – I moved out here from Ohio three years ago. And I learned so many different things, and I found out... a lot of causes were being protested here, and I was really impressed with that. (Pause).

I was hearing... through hearsay from coworkers and other people, and peers, saying that San Francisco is supposed to have a reputation of having some of the best mental health support so far. And I thought that was really interesting, because I'd never heard any other state really be proud of what type of effort they're making. So I just think it'll be very interesting to see what efforts, and what type of potential and growth is possible for the system – contributed by the Board, and the community, and everyone else involved. Just to see exactly what CAN be accomplished. And it'll just be interesting to see that. I want to thank the Board for the outreach to the community, and letting us have this gathering. And let's just see where our efforts can take us. So... (Applause).

MICHAEL MEDEMA: Thank you very much.

---

REBECCA TURNER: Is there anyone else? Yes?

ALEX MCGOWAN: I just have two minor, last comments. One is just, I forgot to mention that in, when we are treating mental health people, patients, there's constant focus on that "This is mandated by the State," and "That is mandated by the State," and so on. What about the patient? What about where they are in their process? How do we focus on them, as well as requirements and regulations?

Second thing I have is a comment about the draft Plan. I know that this is just a draft, but I just want to... induce(?) my perspective a little. I think that... while we have different plans for different ages is beneficial. However, I just want to point out that WITHIN those age groups, there can be some overlaps, and there can be some differences, as well. The issues facing 45 year olds is gonna be different from the issues facing 25 years or so. Also – and there could be overlap between transitional age gr-, transitional age youth and adults, as well. What's facing 23 year olds can be what's facing 25 years, and so on. But it all depend on the individual. So I realize that it's a draft Plan, but I just wanted to point that out, in case you wanted to point that out at some point. (Applause).

REBECCA TURNER: Thank you again. Anyone else? (Pause). Okay. Well, what I'm gonna do at this point is, we're gonna close the Mental Health Board hearing. However, we Board members, at least some of us, will be here until 4:00 o'clock, for several more minutes. So feel free to talk to us at the end. Okay? And thank you again, everybody – thank you for this enormous support. (Applause). The hearing is officially closed.

The meeting was adjourned at 3:50 p.m.



**SAN FRANCISCO MENTAL HEALTH BOARD**



Gavin Newsom  
Mayor

1380 Howard Street, Suite 510  
San Francisco, CA 94103  
(415) 255-3474 fax: 255-3760  
mhb@igc.org  
www.sfgov.org/mental\_health

**MEETING OF THE MENTAL HEALTH BOARD**

Monday, October 24, 2005  
Board of Supervisors Chambers  
City Hall, Second Floor  
1 Dr. Carleton B. Goodlett Place  
Civic Center  
4 p.m. to 7 p.m.

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SEP 23 2005

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**AGENDA**

09-23-05A08:02 RCYD

**CALL TO ORDER**

**ROLL CALL**

**AGENDA CHANGES**

**Item 1.0 PUBLIC HEARING ON THE DRAFT PLAN FOR SAN FRANCISCO'S  
PROPOSITION 63 FUNDING**

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One Carleton Goodlett Way  
Civic Center

Mental Health Board office  
1380 Howard, 5th Floor  
(at the corner of 10th Street)  
from 8:30 a.m. to 5 p.m. weekdays  
415-255-3474

Mental Health Association  
870 Market Street, Suite 928  
San Francisco, CA 94102  
9 a.m. to 5 p.m. weekdays  
415-421-2926

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**ADJOURNMENT**



## **DISABILITY ACCESS**

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Gavin Newsom  
Mayor

Department of Public Health  
**SAN FRANCISCO MENTAL HEALTH BOARD**

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**MEETING OF THE MENTAL HEALTH BOARD**

**Monday, October 24, 2005**  
Board of Supervisors Chambers  
City Hall, Second Floor  
1 Dr. Carleton B. Goodlett Place  
Civic Center  
4 p.m. to 7 p.m.

**DOCUMENTS DEPT.**

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**AGENDA**

**CALL TO ORDER**

**ROLL CALL**

**AGENDA CHANGES**

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## **Item 2.0 PUBLIC COMMENT**

Members of the public may address the Mental Health Board on any items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board.

## **ADJOURNMENT**

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# SAN FRANCISCO MENTAL HEALTH BOARD



Gavin Newsom  
Mayor

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## MEETING OF THE MENTAL HEALTH BOARD

Monday, October 24, 2005  
Board of Supervisors Chambers  
City Hall, Second Floor  
1 Dr. Carleton B. Goodlett Place  
Civic Center  
4 p.m. to 7 p.m.

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### UPDATED AGENDA

10-20-05 10:00 AM

#### CALL TO ORDER

#### ROLL CALL

#### AGENDA CHANGES

#### Item 1.0 PUBLIC HEARING ON THE DRAFT PLAN FOR SAN FRANCISCO'S PROPOSITION 63 FUNDING

Proposition 63, the Mental Health Services Act, was passed on November 2, 2004, by the voters of the State of California. Under Proposition 63, the San Francisco Mental Health Board is required to hold a public hearing on the Draft Plan.

#### Item 2.0 BOARD RECOMMENDATIONS ON THE DRAFT PLAN

For discussion and possible action.

2.1 PROPOSED RESOLUTION: The Mental Health Board hereby forwards the following recommendations to the Department of Public Health in response to public comment regarding the Draft Plan for the Mental Health Services Act...

2.2 PROPOSED RESOLUTION: The Mental Health Board hereby forwards the following official recommendations of the Mental Health Board to the Department of Public Health regarding the Draft Plan for the Mental Health Services Act...

2.3 PROPOSED RESOLUTION: The Mental Health Board hereby forwards the following recommendations to the Department of Public Health from individual Board members regarding the Draft Plan for the Mental Health Services Act...

#### Item 3.0 PUBLIC COMMENT

Members of the public may address the Mental Health Board on any items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board.

#### ADJOURNMENT



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2. For the October 22nd meeting, the Joseph Lee Recreation Center is wheelchair accessible, and the MUNI bus **#15 Third Street** is wheelchair accessible. For the October 24th meeting, City Hall is wheelchair accessible, and the **#47 Van Ness** bus is wheelchair accessible. The nearest MUNI Metro station is the **Van Ness Station**. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.
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**MENTAL HEALTH BOARD**

Minutes of Public Hearing on the Mental Health Services Act (Proposition 63)  
Board of Supervisors Chambers  
City Hall  
1 Dr.Carleton B. Goodlett Place  
San Francisco, CA 94102

**Monday, October 24, 2005**

**4 p.m.**

PLEASE NOTE: This public hearing was televised live over SFG-TV, Channel 26. It will likely be replayed on Channel26,giving members of the public unable to attend the hearing in person, the opportunity to see and hear all the public comments.

When a public hearing is broadcast with captions on the screen, it is a computer program which translates verbal testimony into captions and makes the written transcription of the hearing. Therefore, in the transcription that follows there are some misspellings due to the fact that the computer program was not always able to translate the spoken word into the written word with complete accuracy.

MEMEBERS PRESENT: Rebecca Turner, Ph.D., (Chair); Benito Casados; Supervisor Bevan Dufty; LaVaughn Kellum-King; James Shaye Keys; Claudia Lebish; James L. McGhee; Michael Medema; Toye Moses, Ph.D., M.P.H.; Tom Purvis; Kate Walker; Lisa Williams; Idell Wilson.

MEMBERS ABSENT: Bob Douglas; Dorothy Shaffer, R.N., N.P., M.S.N.; Jagruti Shukla, M.D., M.P.H.; John Kevin Hines.

**AGENDA**

**CALLTO ORDER**

The meeting was called to order at 4:12 p.m. by Rebecca Turner, Chair of the Mental Health Board.

**ROLL CALL**

**AGENDA CHANGES**

No changes to the agenda.

Item 1.0 PUBLIC HEARINGON THE DRAFT PLAN FORPROPOSITION 63, THE MENTAL HEALTH SERVICES ACT

1

>> GOOD AFTERNOON.

THANK YOU FOR BEING HERE.

I'M THE CHAIR-PERSON, REBECCA  
TURNER.

WE ARE PLEASED TO BE IN THE ROLE  
OF FACILITATORS FOR THIS HEARING  
FOR PROPOSITION 63, THE MENTAL  
HEALTH SERVICES ACT.

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UPON AND FOR THE DRAFT PLAN THAT HAS BEEN PREPARED WITH A LOT OF TIME AND A LOT OF CARE BY VARIOUS MEMBERS AND STAKEHOLDERS IN THE CITY OF SAN FRANCISCO. AT THIS TIME, I WOULD LIKE EACH OF THE BOARD MEMBERS TO PLEASE INTRODUCE THEMSELVES, AS YOU INDICATE WHICH SUPERVISOR APPOINTED YOU.

AND AFTER THAT, WE'RE GOING TO MOVE RIGHT TO DR. BOB CABAJ, THE DIRECTOR OF BEHAVIORAL HEALTH SERVICES FOR SAN FRANCISCO. HE WILL GIVE JUST A VERY BRIEF, PROBABLY FIVE MINUTES OR SO OVERVIEW OF THE CITY'S DRAFT PLAN.

AND THEN WE WILL MOVE TO THE HEARING.

PLEASE NOTE THAT IF ANYBODY WANTS TO SPEAK, THESE YELLOW CARDS ARE AVAILABLE.

THEY'RE BEING HANDED OUT BY RICH SNOWEDEN, WHO JUST WALKED OUT, BUT WILL PROVIDE YOU WITH THESE CARDS.

AND WE WILL BE GLAD TO HEAR FROM YOU.

EVERYBODY WILL HAVE THREE MINUTES.

I ALSO WANT TO POINT OUT OUR STAFF MEMBERS, WE HAVE VERY DEDICATED AND VERY TALENTED AND WONDERFUL STAFF MEMBERS FOR THE MENTAL HEALTH BOARD.

MS. BROOKS IS TO MY FAR RIGHT, AND RICH SNOWEDEN IS THERE WITH THE CARDS.

LET'S START.

START WITH LISA WILLIAMS.

>> HELLO, I'M LISA WILLIAMS, I  
HOLD A FAMILY SEAT MEMBER.  
I WAS APPOINTED BY SUPERVISOR  
FIONA MA.  
>> MY NAME IS TOM PURVIS, I'M  
REPRESENTING FAMILIES,  
REPRESENTING NAMI, AND AN  
ORGANIZATION FOR AUTISTIC AND  
ASBERGER'S CHILDREN.  
>> I'M JAMES, I WAS APPOINTED BY  
SUPERVISOR CHRIS DALY, AND I SIT  
ON THE PUBLIC INTEREST SEAT.  
>> IDELL WILSON, I WAS APPOINTED  
BY SOPHIE MAXWELL.  
>> MY NAME IS -- [NO AUDIO.]  
>> MY NAME IS MINE (DINA).  
I WAS APPOINTED BY SUPERVISOR  
DUFTY.  
>> I'M KATE WALKER, APPOINTED BY  
SUPERVISOR ELSBERND.  
>> I'M -- APPOINTED BY  
MR. SALVADOR.  
>> I'M CLAUDIA, I WAS APPOINTED  
TO CONSUMER SEAT BY SUPERVISOR  
ROSS MIRALAIN.  
>> MOSES REPRESENTING THE  
PROFESSIONALS.  
>> GOOD EVENING.  
MY NAME IS LA'VAUGHN  
KELLUM-KING  
I WAS APPOINTED BY SUPERVISOR  
ALIOTO-PIER.  
THANK YOU.  
>> I'M REBECCA TURNER APPOINTED  
BY THE RULES COMMITTEE.  
I HOLD THE MEDICAL PROFESSIONAL  
SEAT.  
WE WILL GO TO DR. SABI.  
>> THANK YOU.  
I HOPE YOU CAN HEAR ME.  
I'M DR. BOB SABI, DIRECTOR OF  
COMMUNITY BEHAVIOR HEALTH  
SERVICES.  
I'M THE OFFICE COUNTY MEDICAL  
HEALTH DIRECTOR OR HEALTH  
ADMINISTRATOR.  
IN MY ROLE, IT IS MY JOB TO TAKE  
THE PLAN, AFTER YOU HAVE  
REVIEWED IT AND AMENDED IT, AND  
SUBMITTED IT WITH THE AMENDMENTS

TO THE DEPARTMENT OF MENTAL  
HEALTH IN SACRAMENTO.

AND THEN OUR HOPE IS THAT THE  
PLAN WILL BE ACCEPTED AND THEN  
WE WILL BE ALLOWED TO TAKE THE  
FUNDING AND USE TO BUILD THE  
CLINICAL SERVICES DESCRIBED IN  
THE PLAN, JUST TO GIVE PEOPLE A  
SENSE OF THE DIRECTION THAT  
WE'RE TAKING WITH THIS.

THE STATE TELLS US THEY WILL  
NEED ABOUT THREE MONTHS OF TIME  
TO REVIEW THE PLAN, AND ONLY  
THEN WILL FUNDING BE AVAILABLE.  
THAT'S WHY I APPRECIATE THE  
TIMELINESS OF THESE HEARINGS AND  
LOOK FORWARD TO HEARING THE  
COMMENTS.

TO GIVE BACKGROUND FOR PEOPLE  
WHO MAY NOT KNOW WHAT WE ARE  
FOCUSING IN ON.

IF YOU RECALL, THERE WAS A  
PROPOSITION 63 THAT WAS VOTED BY  
THE VOTERS IN NOVEMBER, AND IT  
PASSED IN CALIFORNIA, AND IT  
PASSED BY THE WIDEST MARGIN HERE  
IN THE COUNTY OF SAN FRANCISCO.  
IT IS A 1% TAX, OVER 1 MILLION,  
AND GENERATES FUNDING THAT IS TO  
BE USED ON THE COUNTY LEVEL FOR  
MENTAL HEALTH SERVICES .  
THROUGHOUT THE STATE.

THROUGH A SERIES OF FORMULAS  
THAT DECIDED ALLOCATIONS, OUR  
COUNTY WAS GIVEN 5.3 MILLION IN  
CLINICAL SERVICES FUNDING,  
THOUGH WE WERE ALL DISAPPOINTED  
SINCE THE AMOUNT IS MUCH LESS  
THAN WE WERE FIRST LED TO THINK  
WE WOULD RECEIVE, IT IS STILL A  
SIGNIFICANT PORTION OF MONEY FOR  
US.

AND WILL BE USED AS DESCRIBED IN  
THE PLAN THAT YOU HAVE IN FRONT  
OF YOU.

JUST TO POINT OUT THE GOALS OF  
THE MENTAL HEALTH SERVICES ACT  
WERE PLENTY.

LET ME REMIND YOU, THE BIG PLAN  
THAT YOU HAVE IS OVER 200 PAGES

AND IS TECHNICALLY AN APPLICATION TO THE STATE FOR THE FUNDING THAT WE ARE REQUESTING. THAT'S WHY IT LOOKS VERY TECHNICAL AND LOTS OF DETAIL. AND I SUSPECT MANY OF YOU DIDN'T READ EVERY WORD, AND I WOULDN'T BLAME YOU.

AS I'VE SAID TO OTHER GROUPS IT'S A GREAT TOOL FOR INSOMNIA. I WOULD LIKE YOU TO READ THE EXECUTIVE SUMMARY BECAUSE THAT IS THE DESIRE OF WHAT WE WANT TO DO WITH THE FAMILY.

IN THE EXECUTIVE SUMMARY, WHICH WE WILL INCLUDE WHEN WE SUBMIT THE PLAN TO THE STATE, OUTLINES OUR HOPES FOR TRANSFORMING THE MENTAL HEALTH SYSTEM IN SAN FRANCISCO TO BE MUCH MORE CONSUMER-DRIVEN, FAMILY-DRIVEN, COMMUNITY ORIENTED, AND WORKING WITH FAMILY PRACTICES TO DELIVERING THE BEST CARE WE CAN TO OUR POPULATION.

THE GOALS OF THE ACT STATEWIDE WAS TO MAKE SURE THAT THE PUBLIC UNDERSTOOD THAT MENTAL ILLNESS IS SERIOUS, AND THERE ARE CONSEQUENCES FOR NOT TREATING, AND WE NEED ADDITIONAL FUNDING TO MAKE SURE WE MEET THOSE NEEDS.

THE CITY CREATED A TASK FORCE, THE MAYOR MADE A TASK FORCE, CHAIRED BY BARBARA GARCA. IT REVIEWED THE INPUTS THROUGHOUT THE COMMUNITY, AND PEOPLE WHO HELPED RANK THE IDEAS IN THE PLAN.

THE TASK FORCE MET SEVEN TIMES IN SEVEN DIFFERENT NEIGHBORHOODS.

AND WE ALSO HAD 11 SUBCOMMITTEES THAT FOCUSED ON VARIOUS POPULATIONS AS WELL AS NEEDS, SUCH AS HOUSING, HOMELESSNESS AND EDUCATION.

WE HAD MANY INDIVIDUAL INTERVIEWS, GROUP MEETINGS, WE

WENT TO THE COMMUNITY IN SEVERAL WAYS.

SO WE BELIEVE THE ATTEMPT TO GET INPUT FROM THE COMMUNITY WAS AS WIDE-BASED AS POSSIBLE.

GIVEN THE SIZE OF SAN FRANCISCO AND THE VERY LARGE NUMBER OF PEOPLE WITH INTEREST, WE KNOW WE PROBABLY DIDN'T REACH EVERYONE, BUT WE CERTAINLY HAVE TRIED TO MAKE SURE THERE WAS ROAD FOR INPUT INCLUDING SUBMISSIONS OF INPUT PAPERS AND OVER 80 PAPERS WERE FILED.

I THINK YOU WILL FIND THE MOST IMPORTANT MATERIAL IS SUMMARIZED THERE.

EVEN THOUGH THE AMOUNT WE HAVE IS ONLY 5.3 MILLION WE WILL HELP USE THAT FUNDING TO LEAD CHANGES IN ALL THE OTHER FUNDINGS THAT WE HAVE FOR THE CITY.

WE HAVE OVER 200 MILLION DOLLARS IN FUNDING THAT WE ALREADY USE FOR MENTAL HEALTH SERVICES.

THE POLICY STATEMENTS WERE VERY IMPORTANT.

THEY OUTLINED HOW WE WANT MORE CONSUMER INPUT, AND WE WILL BE ASKING COMMUNITY-BASED ORGANIZATIONS TO MAKE SURE CONSUMERS ARE PART OF THEIR BOARD OF DIRECTORS AND SO ON. THERE ARE MANY RECOMMENDATIONS THAT WILL BE IN THE POLICIES THAT YOU WILL SEE.

JUST TO WALK THROUGH, VERY QUICKLY, WHAT WE HOPE TO DO WITH THE MONEY, THE STATE DID ASK THAT THE MAJORITY OF FUNDING BE USED FOR WHAT THEY CALL FULL SERVICE PARTNERSHIPS, WHICH ARE BASICALLY INTENSIVE CASE MANAGEMENT OR OUTREACH, AND ENGAGEMENT WITH CLIENTS WHO HAVE SERIOUS MENTAL ILLNESS, AND THE PHRASE THEY USE IS WHATEVER IT TAKES.

IT'S FUNDING FOR SERVICES THAT CAN BE QUITE BROAD-BASED IN



THEIR INTERVENTIONS TO MAKE SURE THAT PEOPLE WHO NEED CARE ARE GETTING IT.

AGAIN THE LIMITED FUNDING THAT OUR COUNTY HAD WE ESTIMATE WE CAN TREAT AN ADDITIONAL 153 PEOPLE WITH THE FUNDING IN ALL THE AGE GROUPS.

BUT WE HOPE, WITH BALANCE OF REVENUE AND ADDITIONAL FUNDS WE MAY OBTAIN, TO TREAT MORE PEOPLE.

THE OTHER PORTION OF THE FUNDS IS BEING USED FOR WHAT WE CALL COMMUNITY SYSTEMS DEVELOPMENT. AND IT WOULD INCLUDE OUTREACH AND ENGAGEMENT.

WHAT THESE WOULD BE, WOULD BE IDEAS IN PROGRAMS AND STRUCTURES CHANGING HOW WE DO BUSINESS IN SAN FRANCISCO AND ALLOW GREATER OUTREACH AND ENGAGEMENT IN PEOPLE OF ALL AGES.

AS THE STATE REQUIRED, THE PLAN OUTLINES THE FOUR AGE GROUPS. THE STATE CONSIDERED YOUTH, TRANSITIONAL AGE YOUTH, 14-16 AND 18 YEARS OLD AND OLDER, AND OUR MONEY WAS PROPORTIONED ACCORDINGLY.

EACH GROUP HAS SPECIFIC SYSTEM DEVELOPMENT IDEAS, BUT EACH OF THE AGE GROUPS INCLUDED MONEY THAT CAN BE USED TO HELP ENHANCE BEHAVIOR HEALTH SERVICES ARE OFFERED THROUGH OUR PRIMARY HEALTH CLINICS THROUGHOUT THE CITY.

THEY RECOGNIZE THERE ARE NEEDS NOT MET IN TRADITIONAL HEALTH CLINICS SINCE PEOPLE DON'T LOOK FOR CARE IN THOSE AVENUES AND YOUTH WOULD NEED HELP ON THINGS LIKE AUTISTIC, WHICH IS NOT COVERED BY THE STATE, AND OLDER FOLKS WITH DEMENTIA WHICH IS NOT COVERED BY THE STATE.

IN ADDITION, THERE WAS FOCUS ON YOUTH, VIOLENCE AND TRAUMA RECOVERY SET OF SERVICES.

AGAIN, THE RECOGNITION THAT VIOLENCE IS UNFORTUNATELY EVERYWHERE IN OUR CITY, AND CERTAINLY CONCENTRATED IN CERTAIN NEIGHBORHOODS. AND THEN OTHERS, TO HAVE A MORE CONCENTRATED PLAN THAT WILL HELP DEAL WITH THE CONSEQUENCES OF VIOLENCE AND THE PEOPLE WHO HAVE WITNESSED VIOLENCE AND TRAUMA. THERE ALSO WILL BE CULTURALLY SPECIFIC FUNDS FOR ASIAN, LATINO, AFRICAN-AMERICAN, TRANSGENDERAL YOUTH AND TRANSITIONAL AGE YOUTH TO HELP WITH BETTER ENGAGEMENT ALONG THE CULTURAL LINES AND THE SERVICES SENSITIVE TO THOSE NEEDS. OLDER ADULT INCLUDES SUPPORTIVE HOUSING, PARTICULARLY THE TRANSITIONAL AGE YOUTH WE KNOW HAVE TROUBLE ENGAGING IN HOUSING THAT'S FOR REGULAR ADULTS BECAUSE OF THE AGE DISCREPANCY AND THE PREPARATION FOR -- LACK OF PREPARATION FOR LIVING. AND THEN FUNDS FOR MORE PEER-RUN AND CONSUMER-RUN PROGRAMS IN THE COMMUNITY. ONE FOCUS ON YOUTH OUTREACH, ANOTHER FOR ADULT ENGAGEMENT, AND KIND OF AN ALTERNATIVE TO A DROP-IN OR CRISIS CENTER AND OLDER SENIOR ADULT CENTERS, ALLOWING MEDIUM TO -- PEOPLE TO VISIT AND GET MENTAL HEALTH SERVICES AS NEEDED. WE HOPE THE SUMMARY OF THE PLAN, BOTH IN EXECUTIVE SUMMARY AND AT THE VERY END OF THE PLAN, WILL HELP IT BE CLEAR WHAT WE HOPE TO DO WITH THE FUNDS IF THE STATE DOES APPROVE THEM. WE LOOK FORWARD TO HEARING WHAT COMMENTS DO ARISE TODAY AND WILL INCORPORATE THEM INTO ADJUSTMENTS TO THE PLAN. OUR GOAL IS TO TRY TO SUBMIT THE PLAN TO THE STATE BY NOVEMBER 1. WE MAY OR MAY NOT MAKE THAT

TARGET DEPENDING ON HOW MUCH  
INPUT WE HAVE TODAY THAT WE HAVE  
TO INCORPORATE.

BUT WE LOOK FORWARD TO HEARING  
WHAT BOTH THE BOARD AND THE  
PUBLIC HAVE TO SAY, AND REALLY  
LOOK FORWARD TO THE PARTNERSHIPS  
THAT WE HAVE FORGED AND WILL  
CONTINUE TO BUILD ON.  
THANK YOU.

>> Chair Turner: THANK YOU.  
THANKS TO THOSE OF YOU WHO HAVE  
FILLED OUT THE YELLOW FORM.  
A COUPLE OF HOUSEKEEPING THINGS.  
IF YOU NEED A TRANSLATOR, WE DO  
HAVE TRANSLATORS RIGHT OVER  
HERE.

IN SPANISH AND CANTONESE.  
IF YOU NEED ANY OTHER ASSISTANCE  
IN MAKING YOUR COMMENTS, PLEASE  
LET RICH SNOWDEN KNOW.

WHAT I WILL DO IS I WILL HAVE A  
MEMBER OF THE EXECUTIVE  
COMMITTEE HERE, WHO WILL HELP  
WITH CALLING NAMES.

MICHAEL MEDEMA WILL START.  
HE'S BEEN INVOLVED AS COCHAIR.  
WE WILL HAVE IDELL WILSON, LISA  
WILLIAMS AND LAVAUGHN  
KELLUM-KING.

I WILL CALL THE FIRST THREE  
NAMES.

BUT FIRST, MICHAEL WILL TELL YOU  
ABOUT OUR TIME KEEPING AND HOW  
WE DO THAT FOR THESE HEARINGS.

>> GOOD AFTERNOON, EVERYBODY.  
I WILL ALSO REMIND OUR BOARD  
MEMBERS THAT --

>> [NO AUDIO.]

>> Chair Turner: THANK YOU.

>> Secretary Medema: GOOD  
AFTERNOON.

I WOULD LIKE TO REMIND THE BOARD  
MEMBERS TO PULL THE MICROPHONE  
CLOSE TO YOUR FACE BUT NOT HOLD  
THE MICROPHONE WHILE ACTUALLY  
TALKING INTO IT.

TODAY WE WILL BE GIVING  
EVERYBODY THREE MINUTES WORTH OF  
TIME AND CALL PEOPLE THREE AT A

TIME TO GIVE YOU HEADS UP AS TO  
WHEN IT'S YOUR TURN TO SPEAK,  
PLEASE COME UP TO THE PODIUM.  
ONCE YOU START TALKING, YOUR  
THREE MINUTE TIME WILL BEGIN.  
THERE WILL BE A SOFT CHIME AT  
TWO MINUTES AND 30 SECONDS TO  
LET YOU KNOW THAT YOU HAVE 30  
SECONDS LEFT.

THEN THERE WILL BE A LOUD CHIME  
AT THREE MINUTES, LETTING YOU  
KNOW THAT YOUR TIME IS INDEED  
UP.

IF YOU FIND THAT YOU NEED TO  
SUBMIT ADDITIONAL COMMENTS, WE  
CAN ALSO ACCEPT COMMENTS  
AFTERWARDS IN WRITING.

>> Chair Turner: AS YOU CAN  
TELL, THE BOARD HAS IT DOWN TO A  
SCIENCE.

I WOULD LIKE TO NAME THE FIRST  
THREE PEOPLE.

AND PLEASE, WHEN YOU COME UP,  
SAY YOUR NAME.

WE SOMETIMES DO MISPRONOUNCE.  
RAY BARBRAND, CAROLYN COULD  
HAVEMAN, MICKEY SHIPLEY.  
RAY.

>> [NO AUDIO.]

>> Chair Turner: RAY IS WITH  
COMMUNITY RESPONSE NETWORK.

>> I JUST WANT TO SAY IT'S VERY  
IMPORTANT TO KEEP THE PROGRAMS,  
THAT ARE DOING SOMETHING ABOUT  
VIOLENCE IN OUR COMMUNITIES,  
IT'S WRITTEN IN THE PLAN.

WE WANT THAT FUNDED BY THE  
STATE.

WE WANT THAT REPLICATED  
THROUGHOUT THE CITY.

WE DON'T WANT IT AS A  
STAND-ALONE PROGRAM.

I BELIEVE YOU HAVE TO CONNECT  
MORE THINGS TO IT LIKE FAMILY  
SERVICES, ALTERNATIVE SCHOOL  
PROGRAMS, CIVIL RIGHTS  
ADVOCATES.

YOU CAN'T JUST MAKE CHANGE WITH  
A STAND-ALONE PROGRAM.

YOU KNOW WHAT, WE -- THE

COMMUNITY, HAD A GREAT TIME  
DEVELOPING THIS WITH THE TASK  
FORCE.

WE MADE A LOT OF NEW FRIENDS.  
WE WENT TO ALL THOSE MEETINGS.  
WE WENT TO ALL THOSE  
SUBCOMMITTEE MEETINGS, AND ALL  
THOSE THINGS, YOU KNOW.

AND WE DEALT WITH IT.  
AND WE CAME WITH SOME  
INFORMATION THAT WAS NEEDED.  
YOU KNOW, VIOLENCE IS A PUBLIC  
HEALTH ISSUE, YOU KNOW.  
AND VIOLENCE CAN BE PUT DOWN  
WITH A LOT OF SUPPORT AND A LOT  
OF HELP IN THE COMMUNITY.  
I DON'T MEAN LIKE HELP HELP.  
I MEAN LIKE EMPOWERMENT OF THE  
COMMUNITY.

WE STAND HERE BECAUSE WE  
EMPOWERED OURSELVES, COMMUNITY  
RESPONSE NETWORK, EMPOWERING THE  
COMMUNITY TO PREVENT VIOLENCE.  
WE HAVE A LONG HISTORY WITH OUR  
NEIGHBORHOOD MENTAL HEALTH  
SERVICES.

WE DEVELOPED SERVICES, WE  
DEVELOPED TREATMENT PROGRAMS, WE  
DEVELOPED CASE MANAGEMENT  
ASSISTANCE FOR OUR YOUNG PEOPLE.  
SO WE WANT TO ENCOURAGE YOU TO  
DO EVERYTHING YOU CAN TO PREVENT  
VIOLENCE AND PUSH THIS PROGRAM  
THROUGH.

THANK YOU VERY MUCH.

>> Secretary Medema: THANK  
YOU, RAY.

>> GOOD AFTERNOON, MADAM CHAIR  
AND COCHAIR AND THE BOARD.

MY NAME IS MICKEY SHIPLEY.

I AM ALSO A MEMBER OF THE TASK  
FORCE, AND A PAST MEMBER OF THE  
MENTAL HEALTH BOARD.

WE SPENT A LOT OF TIME PUTTING  
THIS PLAN TOGETHER.

I -- COMMEND, YOU KNOW, THE  
MEMBERS OF THE TASK FORCE, THE  
MENTAL HEALTH BOARD, AND, YOU  
KNOW, THE ADMINISTRATION OF  
CPHF, IN PUTTING THIS TOGETHER.

AND ESPECIALLY THE PEOPLE OF  
RDA, WHICH IS THE CONSULTANTS  
THAT HELPED US OUT.  
WE HAVE A LOT OF DATA.  
WE HAD A LOT OF THINGS TO  
CONSIDER.  
WE HAD 82 POSITION PAPERS.  
WE HEARD FROM A LOT OF CONSUMERS  
AND FAMILY MEMBERS.  
AND TRYING TO PUT ALL THAT  
TOGETHER INTO ONE MAJOR PLAN WAS  
VERY, VERY DIFFICULT.  
AND I COMMENT THE PEOPLE WHO  
SPENT THEIR TIME AND THE EFFORT,  
YOU KNOW, IN DOING THIS.  
AND HOPEFULLY WE MET AS MANY  
NEEDS AS POSSIBLE.  
HOWEVER, YOU KNOW, THERE ARE  
THINGS THAT WERE NOT APPROACHED  
AND WERE NOT MET BECAUSE OF  
LIMITED FUNDING THAT WE DID GET  
FROM THE STATE OF CALIFORNIA.  
HOPEFULLY, IN THE PLAN, THAT  
POINTS OUT TO THE STATE THAT WE  
NEED, YOU KNOW, MORE MONEY TO  
ACCOMPLISH WHAT WE WANT.  
THANK YOU.  
>> Secretary Medema: THANK  
YOU, MICKEY.  
>> GOOD AFTERNOON, MY NAME IS  
CAROLYN COULD HAVEMAN, PROGRAM  
DIRECTOR FOR THE CITY AND COUNTY  
OF SAN FRANCISCO MOBILE CRISIS  
TREATMENT TEAM.  
FIRST, I WOULD LIKE TO SAY THAT  
I HAVE BEEN IN AWE OF THE  
DEDICATION, COURAGE AND  
COMMITMENT OF THE CONSUMERS AND  
FAMILIES INVOLVED IN THE  
PROPOSITION 63 PLANNING PROCESS.  
THE EXPANSION OF MOBILE CRISIS  
TO A 24 HOUR PROGRAM RECEIVED  
THE SECOND HIGHEST PRIORITY AND  
WAS ENDORSED BY THE TASK FORCE.  
MY TEAM AND I WERE VERY MOVED BY  
THE SUPPORT OF OUR PROGRAM.  
SO IT WAS A SHOCK FOR ME TO READ  
THAT THE COMMUNITY BEHAVIOR  
HEALTH SERVICES DRAFT AND FIND  
THAT THIS RECOMMENDATION HAD

BEEN IGNORED.

I HAVE HEARD THAT THE COST OF EXPANSION WAS A CONCERN.

DATA ON MOBILE VICES INTERVENTIONS SHOW THAT THE SAVINGS IN ACUTE HOSPITAL DAYS ALLOWS MORE DOLLARS TO BE CONCENTRATED IN OUTPATIENT RESOURCES AND FAMILY SUPPORT.

IN THE LONG RUN, IT IS THE COMMUNITY PROGRAMS THAT HELP PEOPLE FIND A SENSE OF CONNECTIVENESS, FIRST WITH THEIR FAMILIES, AND SECONDLY WITH THE COMMUNITY.

MOBILE CRISIS NOT ONLY DEALS WITH INDIVIDUALS IN CRISIS, THE TEAM ALSO SUPPORTS INDIVIDUALS AND THEIR FAMILIES IN FINDING THE APPROPRIATE LINKAGES WITHIN THE COMMUNITY.

UNLIKE THE SAN FRANCISCO POLICE DEPARTMENT, MOBILE CRISIS CAN SPEND TWO HOURS, FOUR HOURS OR MORE, WHATEVER IT TAKES TO HELP PEOPLE DEAL WITH CRISES.

I HAVE PERSONALLY BEEN INVOLVED WITH THE TRAINING OF OVER 425 POLICE OFFICERS THROUGH THE POLICE CRISIS INTERVENTION TRAINING.

I TEACH SUICIDE ASSESSMENT AT THE SAN FRANCISCO POLICE DEPARTMENT'S ACADEMY AND HAVE TRAINED OVER 391 OFFICERS.

I THINK MOST OFFICERS REALLY WANT TO SEE PEOPLE GET HELP AND LINKED TO THE APPROPRIATE RESOURCES.

ALTHOUGH THE SAN FRANCISCO POLICE DEPARTMENT IS OFTEN THE FIRST RESPONDER TO PEOPLE IN CRISIS, THEY OFTEN DO NOT HAVE TIME TO STAY INVOLVED IN SITUATIONS FOR TWO OR MORE HOURS.

FOR THIS AND OTHER REASONS, THE SAN FRANCISCO POLICE DEPARTMENT HAS ENDORSED A 24 HOUR MOBILE CRISIS.



THE MONEY FROM PROPOSITION 63 IS  
FOR MENTAL HEALTH CLIENTS AND  
FOR THEIR FAMILIES.

I ASK THE MENTAL HEALTH BOARD TO  
STAND BEHIND THE PRIORITIES THAT  
YOU HAVE ENDORSED.

FOLLOW YOUR VISION.

IF COMMUNITY BEHAVIORAL HEALTH  
SERVICES IS SERIOUS ABOUT HAVING  
CLIENTS AND FAMILIES AS PARTNERS  
IN TREATMENT, KEEP  
ADMINISTRATION ACCOUNTABLE TO  
THIS RELATIONSHIP.

THANK YOU VERY MUCH.

>> Secretary Medema: THANK  
YOU.

OUR NEXT THREE SPEAKERS, DALE  
BUTLER, MARILYN SHREK, PAUL  
GIBSON.

>> THANK YOU, MEMBERS.

I'M DALE BUTLER WITH SERVICE  
EMPLOYEES INTERNATIONAL UNION  
790 BUT TODAY I'M REPRESENTING  
THREE DIFFERENT LOCALS, 535, 790  
AND UNITED HEALTH CARE WORKERS  
WEST.

MEMBERS OF THOSE THREE UNIONS  
JOINED TOGETHER TO WORK FOR  
TRANSFORMED MENTAL HEALTH.

WE HAVE ACTIVELY PARTICIPATED IN  
THE PROCESS, COLLECTING  
SIGNATURES TO GET THE ACT  
PASSED, TO GET IT ON THE BALLOT,  
RAISING MONEY, GETTING OUT THE  
VOTES FOR ELECTION.

AND WE HAVE BEEN HEAVILY  
PARTICIPATING IN THE COUNTY'S  
TASK FORCE AROUND MHSA  
IMPLEMENTATION, AND SOLICITING  
INPUT FROM OUR PUBLIC AND  
PRIVATE SECTOR MEMBERS ABOUT  
NEEDS THEY SEE IN THE CURRENT  
MENTAL HEALTH SYSTEM.

WE HAVE REVIEWED SAN FRANCISCO  
DRAFT THREE YEAR PLAN AND HAVE  
THE FOLLOWING TO IMPROVE THE  
PLAN'S ABILITY TO MEET BOTH  
MENTAL HEALTH NEEDS OF  
SAN FRANCISCO RESIDENTS AND  
CORRESPOND TO THE VISION SET

FORTH.

NUMBER ONE, REDUCE FUNDING FOR ADMINISTRATION. THE SPIRIT OF THE ACT IS TO FUND DIRECT SERVICES, NOT ADDITIONAL MANAGERS.

AND LIMITING ADMINISTRATIVE COSTS TO AT MOST 10% WILL PROVIDE MUCH-NEEDED ADDITIONAL SERVICES FUNDING.

NUMBER TWO IS INCLUDE SPECIFICS ON HOW COUNTY WILL USE ADDITIONAL FUNDING IF RECEIVED. WE WANT THE PLAN SPECIFICALLY TO ADDRESS WHAT THE COUNTY WILL FUND, AND HOW IT WILL ARRIVE AT THIS DECISION IF AND WHEN SAN FRANCISCO RECEIVES ADDITIONAL FUNDING FROM THE STATE SET ASIDE.

NUMBER THREE, STRENGTHEN THE CASE FOR RECEIVING THOSE ADDITIONAL FUNDS FROM THE STATE. WE ALL KNOW HOW LITTLE SAN FRANCISCO ENDED UP RECEIVING FROM THE ACT FUNDING, AND WOULD LIKE TO SEE A LOT MORE MONEY COMING INTO THE PUBLIC AND PRIVATE SECTOR.

WE WOULD LIKE TO SEE A STRONGER CASE MADE IN THE PLAN ABOUT HOW WE DEMONSTRATED CAPACITY IN OUR SYSTEM TO PROVIDE ALTERNATIVE COMMUNITY BASED SERVICE THAT ARE THE TYPES OF SERVICES THE ACT LOOKS TO IMPLEMENT.

NUMBER FOUR IS DIRECT FUNDS TO EXISTING UNION PROVIDED SERVICES.

UNION MEMBERS, INCLUDING CLIENT WORKERS, HAVE A STRONGER VOICE IN THE SERVICES THEY PROVIDE, AND HAVE HIGHER WAGES AND BENEFITS.

THIS LEADS TO REDUCED TURNOVER, BETTER CLIENT SERVICE AND IMPROVED SERVICE DELIVERY.

THE FINAL ITEM, NUMBER FIVE, IS REDUCE HIGH END OUT OF COUNTY PLACEMENTS THAT ARE UNNEEDED.

HUNDREDS OF SAN FRANCISCO RESIDENTS ARE BEING SENT OUT OF COUNTY TO IMD'S BECAUSE THEY ARE NOT SUFFICIENT ALTERNATIVES TO INSTITUTIONIZATION THAT EXIST IN THE CITY.

WE NEED TO DEVELOP IN-COUNTY OPTIONS AS PART OF SAN FRANCISCO'S SYSTEM TRANSFORMATION.

I HAVE COPIES OF THOSE COMMENTS. THANK YOU VERY MUCH.

>> Chair Turner: THANK YOU.

WE WOULD APPRECIATE THE WRITTEN COMMENTS.

>> Secretary Medema: MARILYN.

>> MY NAME IS MARILYN SHREK AND I REPRESENT THE OLDER ADULTS IN THE CITY.

I HAPPEN TO BE ONE OF THOSE PEOPLE WHO NEEDED THE SERVICES OF THE MENTAL HEALTH SYSTEM A COUPLE OF YEARS AGO.

AND BY THE GRACE OF GOD AND THE HELP OF MANY, MANY PEOPLE, I HAVE SURVIVED, AND AM CARRYING THE MESSAGE TO THE BEST OF MY ABILITY.

I WOULD LIKE TO READ THE OVERVIEW, FOR THOSE WHO HAVE NOT HEARD IT, OF THE MASA.

IN NOVEMBER 2004, THE VOTERS OF CALIFORNIA PASSED PROPOSITION 63, THE MENTAL HEALTH SERVICES ACT, MHSA.

THE MHSA IS A 1% TAX IN EXCESS OF 1 MILLION.

FUNDS COLLECTED UNDER THAT ACT ARE TO BE USED TO FUNDAMENTALLY CHANGE ACCESS TO AND DELIVERY OF MENTAL HEALTH SERVICES THROUGHOUT CALIFORNIA.

SAN FRANCISCO WIDELY SUPPORTED THIS IN THE BALLOT.

74% OF THE VOTERS WERE IN FAVOR OF IT.

IT'S ESTIMATED AT THAT TIME THAT THERE WOULD BE \$50 MILLION AVAILABLE FOR FUNDS, AND AS IT TURNS OUT, WE HAVE RECEIVED THE

5.3 MILLION.

THIS IS NOT HIGH ENOUGH TO HELP  
PUT THE NEEDS OF OUR CITIZENS,  
WHO ARE LYING IN THE STREETS.  
AND I HAPPEN TO BE STILL GOING  
TO RIPLENS HOUSE, OUT ON 24th  
AND GUERRERO.

AND I SEE A LOT OF PEOPLE WITH  
NO PLACE TO GO.

THEY'RE DESPONDENT.

THEY'VE PRACTICALLY GIVEN UP.

I SEE THEM COMING BACK TO LIFE  
DAY BY DAY.

AND IT'S A DIRECT RESULT OF THE  
MENTAL HEALTH SERVICES PROGRAM  
IN THE CITY.

THANK GOD I'M NOT THERE ANYMORE.

THE MAIN PROBLEM AMONGST --

AMONG SENIORS FOCUSES ON  
ISOLATION, HOSPITALIZATION,  
HOMELESSNESS, SUICIDE, AND  
DEMENTIA.

BY THE WAY, I WAS TOLD THAT I  
HAVE THE BEGINNINGS OF DEMENTIA.

SO I HAVE TO REALLY, REALLY BE  
ON GUARD AND WATCH MYSELF DAILY.

THIS IS NOT UNCOMMON AMONG  
SENIOR CITIZENS.

IT'S EXTREMELY COMMON.

SO I'M GLAD TO SEE THAT THERE  
ARE FUNDS THERE IN CASE I SHOULD  
EVER NEED IT.

THIS MONEY IS NOT ENOUGH TO MEET  
THE NEEDS OF OUR CITIZENS WHO

LIE, DYING IN THE STREETS.

SAN FRANCISCO WILL USE 51% OF  
THIS FUNDING FOR FULL SERVICE  
PARTNERSHIPS.

THIS MEANS THAT CONSUMERS BECOME  
PARTNERS IN THEIR OWN RECOVERY,

WHATEVER IT TAKES TO MAKE THE

DIFFERENCE IN HOUSING,

RELATIONSHIPS, CRISES CASES,

EDUCATION, AND FEWER INVOLUNTARY  
SERVICES.

NOW FOR THE BREAKDOWN OF THESE  
FUNDS.

180,000 A SENIOR RECOVERY CENTER  
FOR HOUSING, INCLUDING --

>> Secretary Medema: THANK

YOU, MARILYN.

>> IS THAT IT?

>> Secretary Medema: THAT'S  
IT.

>> AND AN ADDITIONAL 172,000 AND  
300,000.

THANK YOU FOR YOUR SUPPORT AND  
FOR YOUR HARD WORK AND  
DEDICATION.

>> Secretary Medema: THANK  
YOU.

PAUL GIBSON.

>> MY NAME IS PAUL GIBSON,  
DIRECTOR OF THE YOUTH DEPARTMENT  
FOR JEWISH VOCATIONAL SERVICE.  
WE PROVIDE VOCATIONAL TRAINING,  
EMPLOYMENT AND EDUCATION  
SERVICES FOR MORE THAN 600 YOUTH  
WITH LEARNING, MENTAL HEALTH AND  
PHYSICAL DISABILITIES ANNUALLY.  
I'M ALSO THE COCHAIR OF THE ITOP  
INTERAGENCY COUNCIL, AND ITOP  
STANDS FOR IMPROVING TRANSITION  
OUTCOME PROJECTS FOR YOUTH WITH  
DISABILITIES.

WE ARE A COLLABORATION OF 25  
PUBLIC AND PRIVATE SERVICE  
AGENCIES IN SAN FRANCISCO THAT  
HAS BEEN MEETING THROUGHOUT THE  
YEAR AND IS CURRENTLY CONDUCTING  
COMMUNITY NEEDS ASSESSMENT,  
RESOURCE MAPPING, AND STRATEGIC  
PLANNING FOR TRANSITION SERVICES  
FOR YOUTH WITH DISABILITIES.  
AND I WANT TO COMMEND THE MENTAL  
HEALTH TASK FORCE FOR THEIR  
EXTENSIVE EFFORTS IN DEVELOPING  
THIS PLAN, AND SPECIFICALLY TO  
FOCUS ON THE TRANSITION-AGED  
YOUTH RECOMMENDATIONS, AND TO  
LET YOU KNOW THAT I SUPPORT  
THOSE RECOMMENDATIONS.

I WANT TO COMMEND THE TASK FORCE  
FOR, FIRST OF ALL, PROVIDING  
SUBSTANTIAL RESOURCES TO ADDRESS  
THE NEEDS OF YOUTH, AGES 16-24,  
WHO ARE IN GREATEST NEED, IN  
MAKING THE DIFFICULT TRANSITION  
FROM HIGH SCHOOL TO INDEPENDENT  
LIVING.

I THINK TOO OFTEN WE HAVE TRIED TO GET OFF TOO CHEAPLY IN HELPING PEOPLE IN THE COUNTRY AND I THINK IT'S A SINCERE EFFORT TO PROVIDE THESE YOUTH WITH THE SERVICES THEY NEED.

I WANT TO SUPPORT THE COMPREHENSIVE SERVICES APPROACH. WHEN A CHILD DOES FALL BEHIND IN OUR SOCIETY, IT TAKES EXTENSIVE EFFORTS IN A LARGE NUMBER OF AREAS IN ORDER TO BRING THAT CHILD BACK UP TO A LEVEL PLAYING FIELD.

AND I ALSO WANT TO COMMEND THE TASK FORCE FOR RECOGNIZING THAT YOUTH IN SAN FRANCISCO, WITH THE GREATEST NEEDS, HAVE MULTIPLE RISK FACTORS AND ARE INVOLVED IN MORE THAN ONE SYSTEM OF CARE.

I KNOW FROM MY EXPERIENCE, WHETHER IT'S YOUTH WITH DISABILITIES, OTHERWISE KNOWN AS SPECIAL EDUCATION, OR FOSTER CARE, JUVENILE JUSTICE, HOMELESS YOUTH, THAT THERE'S TREMENDOUS OVERLAP BETWEEN ALL OF THOSE DIFFERENT POPULATIONS, AND WE'VE GOT TO START LOOKING AT AND PROVIDING SERVICES FOR THOSE YOUTH, RECOGNIZING THAT FREQUENTLY THEY'RE ALWAYS THE SAME YOUTH.

YOUTH WITH SERIOUS MENTAL HEALTH ISSUES FACE NUMEROUS BARRIERS TO MAKING A POSITIVE TRANSITION TO ADULTHOOD.

WE KNOW THAT WITHOUT INTENSIVE INDIVIDUAL AND SPECIALIZED SUPPORT THAT THEY ARE FAR LESS LIKELY TO SUCCEED.

THEY HAVE MUCH HIGHER RATES OF NOT COMPLETING HIGH SCHOOL, NOT ATTENDING COLLEGE, AND HIGHER RATES OF POVERTY AS ADULTS. THEY HAVE HIGHER RATES OF INVOLVEMENT WITH THE JUSTICE SYSTEM AND PREGNANCIES.

20% OF TRIAL RUNS OF THE HIGH SCHOOL EXIT PLAN AND ONLY A

THIRD OF THE ADULTS WITH  
DISABILITIES HAVE EITHER PART OR  
FULL TIME EMPLOYMENT.

>> Secretary Medema: THANK  
YOU.

>> I WANT TO SAY ONE LAST  
SENTENCE.

I WANT TO STRESS THE IMPORTANCE  
OF WORKING TOWARDS EMPLOYMENT  
AND EDUCATIONAL OUTCOMES WITH  
THE TRANSITIONAL AGE YOUTH IN  
HELPING THEM TO MAKE A  
SUCCESSFUL TRANSITION TO  
ADULTHOOD AND PREPARE FOR  
INDEPENDENT LIVING.

>> Secretary Medema: THANK  
YOU.

OUR NEXT SPEAKERS, STAIR DAVIES,  
PAUL CLEM, AND MICHAEL WEISS.

>> HAS WHO ARRIVED?

>> [NO AUDIO.]

>> THAT'S BARBARA GARCA.

>> GOOD EVENING, LADIES AND  
GENTLEMEN, AND EVERYONE HERE  
THAT'S IN SUPPORT OF OUR MENTAL  
HEALTH INITIATIVE FOR  
EMPOWERMENT AND WELLNESS AND  
WELL BEING TO THE PEOPLE  
INFLECTED BY MENTAL ILLNESS.

I'M MS. DAVIES.

HAVING GONE INTO THE STREET  
CONSISTENTLY AND TWO YEARS  
CONTINUOUSLY, TAKING PEOPLE IN  
HAND AND LITERALLY TAKING AND  
CARRYING THEM TO WHERE THEY  
NEEDED TO GO, EVERY STEP, THAT  
WOULD LEAD THEM INTO HOUSING.  
MY THOUGHTS WERE ABOUT MENTAL  
ILLNESS IS IF YOU STAY OUT THERE  
LONG ENOUGH IN THE STREETS YOU  
CAN'T HELP BUT BECOME MENTALLY  
ILL.

I'M HEARING ABOUT ALL OF THE  
MONEY THAT'S HERE.

THERE'S NOT A LOT OF IT.

BUT, YOU KNOW WHAT, I THINK  
WHAT'S IMPORTANT, AND THE  
MESSAGE I WANT TO SEND IS, EVEN  
IF I DID THIS INDEPENDENTLY  
CONTRACTING, AS OUTREACH IS



CRITICAL.

PEOPLE ARE FEELING REALLY BAD,  
AND BEING ABLE TO BE UPLIFTED  
AND TAKEN SOMEWHERE.

AND WHEREVER THEY GO, NO MATTER  
WHICH NEIGHBORHOOD WITH ALL OF  
THESE PROGRAMS, THAT THERE IS  
SOME CONSISTENCY, AND THAT  
CONSISTENCY SHOULD BE -- THE  
BOTTOM LINE IS WE'RE TRYING TO  
GET THEM BACK TO MENTAL HEALTH.  
INSTEAD OF ALL THESE PROGRAMS, I  
BELIEVE ALL THE PROGRAMS SHOULD  
SHARE.

NOT WHO'S THE BEST OR WHO ISN'T,  
WHO'S GOING TO GET THE MOST  
DOLLARS.

IF WE DON'T SHARE OUR SUCCESSES  
AS WELL AS FAILURES, WE ARE NOT  
HELPING THE PEOPLE THAT ARE  
MENTALLY ILL.

THAT HAS ALWAYS BEEN MY  
PHILOSOPHY.

I SAY THROUGH THE PROCESS, FOR  
PEOPLE TO BE WITHIN THEIR HOMES  
WITHIN A YEAR.

IT IS A PROCESS I TALKED ABOUT  
CONSISTENTLY.

PROJECT CONNECT IS HERE, AND  
IT'S ENORMOUS.

MY ONLY THING ABOUT THAT IS I  
FEEL THERE SHOULD BE, IF THERE'S  
FUNDING, A PROJECT CONNECT FOR  
PEOPLE THAT ARE MENTALLY ILL. .

THERE ARE PEOPLE OUT ALL TIMES  
OF THE NIGHT AND CAN'T WAIT TILL  
THE MORNING UNTIL THIS BUS COMES  
OR THAT BUS COMES.

THAT FIRST CONNECTION IS  
CRITICAL.

WHEN YOU HOLD ON TO THEM AND  
DON'T LET THEM GO, I BELIEVE  
THAT'S IT.

I HAVE SEEN PEOPLE WHO ARE  
MENTALLY ILL BECOME BETTER.  
I'VE DEALT WITH SUCH PEOPLE.  
AND I AM ONE.

WE PULL ALL OF OUR STRENGTH  
TOGETHER AND STOP WITH THE  
COMPETITIVE DOLLARS OF WHICH

ORGANIZATION IS GOING TO GET ONE.

BECOME STRONG AS ONE.

WE WILL SEE MENTAL ILLNESS -- MAYBE NOT DISAPPEAR BUT A BIG CHUNK OF IT LEAVING.

AND THIS IS WHAT I HOPE FOR.

THANK YOU.

>> Secretary Medema: THANK YOU.

PAUL QUINN.

>> GOOD AFTERNOON.

MY NAME IS PAUL QUINN.

I'M A MEMBER OF THE

DEPRESSIVE -- THAT WAS QUICK.

>> Chair Turner: PARDON THAT.

>> I'M'S A MEMBER OF THE

DEPRESSIVE AND BIPOLAR ALLIANCE

AND IN AN EFFORT TO AID THE

PEOPLE WHO ARE RECOVERED AND

RECOVERING FROM BIPOLAR AND

DEPRESSIVE DISORDER.

A SERIES OR A CONGLOMERATION OF

SYMPTOMS, WHICH AFFECT 69,000

CONSERVATIVELY SAN FRANCISCANS

EVERY YEAR.

AT PRESENT, THIS GROUP OF PEOPLE

IS GIVEN ABSOLUTELY NO MONEY BY

THE CITY.

I ASSUME THAT'S BECAUSE IT WAS

ONLY RECOGNIZED AS AN ILLNESS IN

THE 70'S AND EFFECTIVE

MEDICATIONS ONLY ARRIVED IN THE

90'S AND THE MENTAL HEALTH

SYSTEM IS UNUSED TO DEALING WITH

PEOPLE LIKE US.

A LIVE TIME OF STUNTED

PROFESSIONAL AND PERSONAL

RELATIONSHIPS HAS BEEN RELIEVED

BY THE NEW MEDICATIONS.

NEVERTHELESS, THERE HAS BEEN NO

PROVISO MADE FOR TAKING CARE OF

THESE INDIVIDUALS.

THE WORK OR THE PROGRAM OF THE

VARIOUS MENTAL HEALTH

INSTITUTIONS IS TO TREAT THEM

TRADITIONALLY, LIKE ALL THE

MENTAL ILL, PEOPLE WITH

SUBNORMAL IQ'S, SUBSTANCE

ABUSERS, WHO HAVE PHYSICAL

DISABILITIES CAUSED BY THEIR MENTAL ILLNESS, SO THEY ARE PROVIDED WITH JOBS, QUOTE UNQUOTE, THAT INVOLVE REPETITIVE MOTIONS OF SIMPLE CHORES LIKE MOPPING THE FLOORS OR SERVING COFFEE.

FOR A PERSON WHO IS OF EVEN NORMAL INTELLIGENCE, WHO HAS BEEN RELIEVED OF A LEADEN CLOAK OF DEPRESSION, OR WHO HAS BEEN RELIEVED OF THE TOUCH OF BIPOLAR ILLNESS THAT SENDS THEM INTO DESPAIR AND PERHAPS UNRATIONAL OR IRRATIONAL EUPHORIA, TREATING THEM LIKE OTHER MENTAL ILLNESS IS LIKE -- IS HARDLY PREFERABLE TO SHOOTING THEM IN THE HEAD. THEY'RE NOT THE CANDIDATES FOR THE TYPICAL MENTAL HEALTH SOLUTIONS THAT YOU'RE OFFERING, AND IN FACT YOU DON'T OFFER ANYTHING TO THEM BECAUSE YOU DON'T RECOGNIZE THEM. YOU SHOULD KNOW THAT SINCE THE 90'S, THIS GROUP HAS EMERGED BECAUSE OF THE NEW MEDICATIONS, AND WE NEED SOME MONEY FROM YOU FOLKS, AND YOU'RE GIVING US NOTHING.

EVERYTHING IS VOLUNTEER. IT'S TIME FOR YOU TO START SUPPORTING THE 69,000 SAN FRANCISCANS WHO ARE VICTIMS OF THIS ILLNESS, AND THE PROPOSAL THAT YOU OFFER GIVES NO MONEY WHATSOEVER, DESPITE THE PROPOSAL WE OFFERED FOR A MODEST AMOUNT.

THANK YOU.

>> Secretary Medema: THANK YOU.

AND MICHAEL WEISS.

>> GOOD AFTERNOON.

MY NAME IS MICHAEL WEISS.

I'M EDITOR OF THE BAY NEWSLETTER.

I WOULD LIKE TO THANK EVERYBODY INVOLVED WITH PUTTING THE PLAN TOGETHER.

I KNOW IT WAS A MAJOR WORK AND  
MAJOR EFFORT MADE ON OUR BEHALF.  
AND I WANT TO TELL YOU THAT I,  
FOR ONE, APPRECIATE IT.  
SECONDLY, I AM EDITOR OF VOICES  
AT BAY.

THAT'S MY OWN PERSONAL PET  
PROJECT.

BECAUSE OF FUNDING ISSUES AND --  
I COULDN'T REALLY NAVIGATE DOING  
IT ALL BY MYSELF THIS YEAR.

THERE HASN'T BEEN A NEW ISSUE  
OUT SINCE ABOUT A YEAR AGO.  
BUT THE SENTIMENT IN THE MENTAL  
HEALTH COMMUNITY IS IT'S AN  
IMPORTANT VEHICLE OF EDUCATION  
FOR OUR PEERS.

SO I WANT TO LEAVE COPIES OF  
VOICES AT BAY AND THE POSITION  
PAPER THAT WAS WRITTEN ON ITS  
BEHALF BY THE CLIENT COUNCIL  
WITH YOU, IF I MAY.

IN KEEPING THE EMPHASIS OR THE  
FOCUS ON VOLUNTARY TREATMENT,  
AND LESS ON THE RESTRICTIVE  
MANDATORY HOSPITAL MODEL, I WANT  
TO REEMPHASIZE THE PURE BASE  
NEEDS OF OUR MAJOR SHAREHOLDERS,  
THE CLIENTS THAT CAME UP IN  
SUBCOMMITTEE AFTER SUBCOMMITTEE,  
AND MANY OF THE TASK FORCE  
MEETINGS THAT MET.

ONE, VOCATIONAL PROGRAMS HAVE TO  
BE INCREASED AND VARIED,  
OFFERING A WIDER ARRAY OF  
EMPLOYMENT POSSIBILITIES.  
PEER-BASED EMPLOYMENT  
OPPORTUNITIES SHOULD ALSO BE  
INCREASED.

PROGRAMS SHOULD INCLUDE  
COUNSELING -- PEER COUNSELING  
AMONG THE STAFF.  
CENTERS AND CLUBHOUSE MODELS  
SHOULD BE CREATED WITH THAT IN  
MIND.

FUNDING SHOULD BE FOUND TO  
BETTER EQUIP THOSE MODELS THAT  
ALREADY EXIST.

FOR EXAMPLE, SPIRIT MENDERS,  
HYDE STREET CLUBHOUSE AND OASIS

OF SELF-HELP.

TWO, IMPROVE QUALITY OF LIFE FOR THOSE ALREADY IN ASSISTED LIVING SITUATIONS, SUCH AS RESIDENTIAL CARE FACILITIES.

SOCIALIZATION OPPORTUNITIES MUST BE CREATED, SUCH AS THAT OFFERED BY THE STEP PROJECT.

TICKETS TO SPECIAL EVENTS, CONCERTS, MOVIES AND BALLGAMES MIGHT ALSO BRING RESIDENTS OUT OF THEIR OWN DOLE DRUMS.

INCENTIVES SHOULD BE MADE TO PLACES TO CREATE MORE INDEPENDENT LIVING QUARTERS FOR PEOPLE ALREADY READY TO MOVE ON. AND, THREE, THE 24 HOUR DROP-IN CENTER SHOULD MOVE FROM AN IDEA WHOSE TIME HAS COME TO REALITY, WHERE CLIENTS CAN GET HELP SHORT OF BEING HOSPITALIZED.

THE CENTER SHOULD BE PEER-BASED WITH PROFESSIONALS AVAILABLE FOR CASES MORE URGENTLY IN NEED OF MEDICATION AND TREATMENT.

ALSO CARE AND SERVICES SHOULD NOT BE ALL CULTURALLY COMPETENT BUT DEMOGRAPHICALLY COME TENT TO MEET THE NEEDS OF FUTURE GENERATION.

PEER BASED COUNSELING COULD BE A PART OF THIS EQUATION.

THANK YOU.

>> Chair Turner: THANK YOU. OUR NEXT THREE SPEAKERS, PAUL, MARIA, AND FISHER, FROM PATIENT RIGHTS.

PAUL.

PAUL CANGUS.

>> HI.

MY NAME IS PAUL CANGUS, COMMISSIONER PAUL CANGUS.

THE PROPOSAL I HAVE WILL COST ABOUT 10 CENTS AND IS BASED ON PREVENTION.

THE EASIEST WAY TO TEST IF SOMEBODY IS SUICIDAL OR HOMICIDAL, MENTALLY ILL IS THE HAIR TEST WELL KNOWN AMONG BIOLOGIST AND PSYCHOLOGISTS.

IT'S EASY TO PREVENT CASES OF  
MENTAL ILLNESS AND VIOLENCE IF  
WE WOULD DO IT.  
THE CASE OF THE WOMAN WHO TOSSED  
HER THREE KIDS IN THE BAY DUE TO  
POST PARTUM PSYCHOSIS COULD HAVE  
BEEN PREVENTED FOR 10 CENTS  
WORTH OF LITHIUM.  
I GAVE YOU CUPS OF THE STUDY  
DONE BY DR. DEARHEART, WHO FOUND  
COUNTIES IN TEXAS HAD EXTREMELY  
LOW SUICIDE RATE AND HOMICIDE  
RATE.  
HE STARTED A STUDY.  
WHAT HE FOUND WAS THAT THIS ONE  
COUNTY IN TEXAS SITS ON THE  
LARGEST DEPOSIT OF NATURALLY  
OCCURRING ORGANIC LITHIUM IN THE  
WORLD.  
LITHIUM IS NOT A DRUG, CONTRARY  
TO WHAT MEDICAL DOCTORS TELL  
YOU.  
IT'S AN ORGANIC MINERAL YOU CAN  
PURCHASE AT ANY HEALTH FOOD  
STORE.  
I'VE PURCHASED IT FOR YEARS.  
IT'S BEEN AVAILABLE FOR TWO  
YEARS.  
THE STUDY IN TEXAS IS NOT --  
IMPORTANT AND PEOPLE SHOULD BE  
AWARE THAT LITHIUM AND CHROMIUM  
CAN PREVENT A LOT OF SUICIDES.  
IT'S INEXPENSIVE AND IS  
AVAILABLE -- THE SUBWAY PROVIDES  
CHROMIUM IN ONE OF THEIR DRINKS.  
IT'S COMMONLY KNOWN AMONG WEIGHT  
LIFTERS.  
WE NEED TO PROVIDE LITHIUM IN  
SCHOOLS TO PREVENT SUICIDES AND  
HOMICIDES.  
WE CAN REDUCE OUR HOMICIDE  
MURDER RATE IN THE CITY OF  
SAN FRANCISCO BY 70% BY  
PROVIDING 10 CENTS WORTH OF  
LITHIUM A DAY IN FIRST PERIOD TO  
STUDENTS IN HIGH SCHOOLS, MIDDLE  
SCHOOLS AND GRADE SCHOOLS.  
IT'S A NORMAL MINERAL YOU NEED.  
IN CATS AND DOGS, THEY GET 12  
MINERALS IN DOG FOOD.

BABY FOOD GETS FOUR OR FIVE  
MINERALS.

THE DOGS AND CATS IN THE COUNTRY  
GET BETTER FOOD THAN THE PEOPLE,  
AND THAT'S THE REASON DOGS LIVE  
LONGER NOW THAN THE PEOPLE, IF  
YOU COUNT DOG YEARS.

YOU UNDERSTAND WHERE I'M GOING.

WE CAN FUND ALL OF THIS IF WE  
STOP FUNDING THE WAR.

EVERY ELECTED OFFICIAL IN THIS  
CITY HAS GOT TO START MARCHING  
AGAINST THIS WAR.

THIS IS THE TAIL THAT WAGS THE  
DOG.

IF THE ELECTED OFFICIALS IN THIS  
COUNTY DON'T SPEAK OUT AGAINST  
THE WAR, WHAT ARE THE ELECTED  
FOR?

WE PASSED APPROPRIATION N WHICH  
SAID 80% OF THE CITY IS OPPOSED  
TO THE WAR.

WE WANT THE MONEY TO FUND HUMAN  
NEEDS, NOT THE WAR.

I GO TO THESE MARCHERS, EVEN  
THOUGH I'M A COMMISSIONER AND  
WORK IN THE JAILS WITH MENTALLY  
ILL PEOPLE.

YOU DON'T SEE ELECTED OFFICIALS  
IN THIS TOWN MARCHING AGAINST  
THE WAR.

WE NEED THE MONEY HERE, NOT IN  
IRAQ.

THANK YOU.

>> THANK YOU.

MARIA PACKLOOSESKI.

AM I RIGHT?

ARE YOU MARIA?

IS SHE HERE, MARIA PACKLOOSESKI?

OKAY.

FROM SAN FRANCISCO COMMUNITY  
CLUBHOUSE IN THE SUNSET

COMMUNITY DISTRICT.

BANCHER.

>> HI.

FIRST OF ALL, I WANT TO THANK  
THOSE THAT HAVE MADE THIS  
TREMENDOUS EFFORT -- I'M SORRY.  
WHAT?

>> I'M SANDRA LARSON, A



CONSUMER, AND I'M ALSO A MENTAL HEALTH RIGHTS ADVOCATE WITH THE RIGHTS ADVOCACY SERVICES.

I ATTENDED TASK FORCE MEETINGS AND BROUGHT UP THE IMPORTANCE OF MENTAL HEALTH RIGHTS ADVOCACY I DON'T SEE IT MENTIONED.

THE WHOLE ISSUE OF A CLIENT DIRECTED RECOVERY BASED SYSTEM IS ALREADY A STATUTORY RIGHT, A CIVIL RIGHT.

AND THIS IS IMPLEMENTING IT. THAT IS WHY OUR AGENCY IS DIRECTLY INVOLVED IN THE PROCESS.

WE DO EDUCATION AND TRAINING BECAUSE WE HAVE INTIMATE KNOWLEDGE OF PATIENT'S RIGHTS ISSUES.

EXPERIENCE WITH SECLUSION AND RESTRAINT DRIVES CLIENTS OUT OF THE SYSTEM.

NEW LAW THAT CONSUMERS ADVOCATES PUSHED FOR MANDATE THE CLIENT INPUT BE INCORPORATED THROUGHOUT INCLUSION AND RESTRAINT IN MANAGING THEIR CRISIS.

THERE NEEDS TO BE MORE OF A PARTNERSHIP IN THE INFORMED CONSENT PROCESS BECAUSE IT IS THE CLIENT THAT TAKES THE RISK OF TAKING THESE MEDICATIONS AND THEY HAVE A RIGHT TO A CHOICE OF MEDICATION.

RIGHTS VIOLATIONS SHOULD GO WAY DOWN UNDER A SYSTEM LIKE THIS. VOLUNTARY TREATMENT IN FACILITIES SHOULD INCREASE.

VOLUNTARY STATUS IS IMPORTANT. IT MEANS RESPECT AND WORKING IN PARTNERSHIP.

THIS MENTAL HEALTH SYSTEM, IN MY EXPERIENCE, CLIENTS ARE STILL -- IT'S CLIENT FOCUSED BUT STILL CONSISTS OF MAKING CHOICES ON BEHALF OF THE CLIENT A LOT OF TIMES.

I'VE HEARD FROM CLIENTS THAT BEING A PARTNER CONSISTS OF WHAT ONE IS TOLD AND NOT RESISTING.

SADLY SOME CLIENTS NEVER LEARN  
TO FEND FOR THEMSELVES AND IT'S  
NOT BECAUSE THEY ARE  
SCHIZOPHRENIC.

SO I HOPE THIS WILL CHANGE.  
IN ORDER FOR CLIENTS TO HAVE A  
GOOD QUALITY OF LIFE THEY HAVE  
TO LEARN THEIR RIGHTS, AND HOW  
TO ADVOCATE FOR THEMSELVES.  
THAT IS WHY SELF-HELP IS SO  
IMPORTANT.

PLACES LIKE SPIRIT MENDERS AND  
THE OFFICE OF SELF-HELP ARE  
TERRIFIC RESOURCE FOR CLIENTS.  
AND THEY'RE UNDERSERVED CLIENTS  
IN SUPPORTED HOUSING.  
SERVICES ARE NEEDED TO MORE  
DIVERSITY SERVICES, MEDICAL  
TREATMENT, INVOLVEMENT IN  
ACTIVITY, RESIDENT COUNCILS,  
WHICH IS A RIGHT BUT IT USUALLY  
DOESN'T HAPPEN.

ALL CLIENTS NEED TO GAIN BACK  
SOME OF WHAT THEY LOST BECAUSE  
OF THEIR ILLNESS.

THE SIDE EFFECTS AND THE DEMAND  
THEY REMAIN SEGREGATED PERSONS  
WITHIN THE COMMUNITY.

THEY DON'T NEED TO BE MANAGED.

THEY NEED TO BE INCLUDED AND  
HAVE A FAMILY GROUPING, GO TO  
SCHOOL, VOLUNTEER, LEARN TO  
BUDGET, KNOW THEIR RIGHTS.

AND I HOPE THIS IS WHAT IS GOING  
TO BE HAPPENING.

THANK YOU.

>> (APPLAUSE.)

>> THANK YOU VERY MUCH.

LESLIE FROM SAGE.

PLEASE, CAN YOU GUYS STATE YOUR  
NAME WHEN YOU COME TO THE MIC.  
THANK YOU.

>> GOOD AFTERNOON, MY NAME IS  
LESLIE BRIANER, PROGRAM MANAGER  
OF YOUTH SERVICES AT SAGE.  
AS YOU KNOW SAGE HAS A VERY  
LONG-STANDING TRADITION AND IS  
AN AGENCY THAT IS STRONGLY BUILT  
ON THE FOUNDATION OF PEER  
COUNSELING.

SO THE FIRST THING I WANTED TO DO IS REALLY SUPPORT YOUR ACKNOWLEDGMENT OF THE NEED FOR PEER COUNSELING, THE NEED FOR CULTURAL COMPETENCY, THE USE OF THE YOUTH DEVELOPMENT MODEL AND YOUR ACKNOWLEDGMENT OF THE FACT THAT TRAUMA, VICTIM WITNESS AND VIOLENCE WITNESS IS CRUCIAL TO THE SUPPORTIVE SERVICES THAT WILL ENGAGE ALL OF THESE DIFFERENT DEMOGRAPHICS. SPECIFICALLY, I WANT TO UNDERScore THE NEED FOR SERVICES FOR TRANSITIONAL AGE YOUTH.

I THINK THAT YOUR BLANKET STATEMENT THAT TRANSITIONAL AGE YOUTH FALLS THROUGH THE CRACKS IS A RED FLAG.

IN MY LONG TIME AS A SERVICE PROVIDER AND IN MY OBSERVATION, THERE IS NOT THE FOUNDATION ESTABLISHED FOR TRANSITIONAL AGE YOUTH AS THERE ARE FOR THE OTHER THREE DEMOGRAPHICS.

THROWING MONEY AT THEM AND FUNNELING MONEY INTO THE SERVICES IS NECESSARY BUT I THINK YOU'RE STARTING SEVERAL STEPS BACK.

SAGE HAS RECENTLY OPENED THE STATE'S HOUSE FOR GIRLS, A RESIDENTIAL PLACEMENT FACILITY FOR GIRLS ESCAPING VICTIMIZATION AND SEXUAL EXPLOITATION BUT THERE ARE NO SERVICES TO TRANSITION THEM WHEN THEY AGE OUT OF THE SYSTEM.

WE HAVE A FLEDGLING PROGRAM THAT IS SERVICING TRANSITIONAL AGE YOUTH BUT IT IS THE ONLY ONE IN THE CITY AND WE ARE IN EARLY STAGES OF ITS IMPLEMENTATION IN IDENTIFYING WHAT RESOURCES WE HAVE IN THE COMMUNITY TO INTERFACE AND SERVE THESE YOUNG LADIES.

I SUPPORT YOUR ACKNOWLEDGMENT OF THAT AND HAVING WORKED WITH MANY, MANY DIFFERENT

DEMOGRAPHICS, THERE IS ALWAYS,  
ALWAYS THE NEED TO SERVE  
TRANSITIONAL AGE YOUTH AND  
HOPEFULLY SAGE WILL BE  
IDENTIFIED BECAUSE WE'VE  
DEFINITELY ACKNOWLEDGED THEM AND  
DEFINITELY WANT TO CONTINUE TO  
WORK WITH THEM.

THEY'VE BEEN UNDERSERVED AS  
YOUTH AND WILL CONTINUE TO GO ON  
AND BE UNDERSERVED AS ADULTS  
UNLESS SOMETHING HAPPENS NOW.  
OBVIOUSLY A GREAT DEAL OF  
THOUGHTFULNESS AND CLEAR AND  
CONCISE THINKING WENT INTO THIS  
PROGRAM.

THE OTHER THING I WANTED TO  
COMMENT ON IS I'M CURIOUS WHAT  
THE PROCESS WILL BE AS FAR AS  
HOW YOU'RE IDENTIFYING YOUR FULL  
SERVICE PARTNERSHIP  
PARTICIPANTS.

FROM A WRAPPED SERVICES  
STANDPOINT I THINK IT'S A  
FABULOUS IDEA BUT IT'S A SMALL  
PERCENTAGE OF THE DEMOGRAPHICS  
THAT WILL BE SERVED.

I HOPE IN THE FUNNELING OF MONEY  
INTO SYSTEMS DEVELOPMENT THAT  
SOMETHING THAT IS VERY MUCH  
TAKEN INTO CONSIDERATION AND  
THAT IT'S WONDERFUL THAT THEY  
WILL -- THAT VERY SMALL GROUP OF  
PEOPLE WILL RECEIVE ALL OF THESE  
WRAPPED SERVICES BUT IT IS MY  
HOPE THAT THAT WILL BE BUDGETED  
FOR AND WILL BE EXPANDED,  
BECAUSE IT'S JUST GOING TO BE  
SUCH A SMALL PART OF THE  
POPULATION.

THANK YOU AGAIN FOR YOUR TIME  
AND CONSIDERATION.

>> Board Member Wilson: THANK  
YOU.

RAMONE FROM THE ASIAN PACIFIC  
ADVOCACY NETWORK.

>> GOOD AFTERNOON.

I'D LIKE TO FIRST START OFF BY  
THANKING BARBARA GARCA AND  
DR. SABI, MEMBERS OF THE

BEHAVIORAL HEALTH INVASION TASK FORCE, AND THE COMMUNITY MEMBERS THAT PARTICIPATED IN THIS PROCESS.

IT WAS A LONG GRUELING PROCESS AND A PLAN CAME OUT, WHICH IS A GOOD START, VERY GOOD START. AS STATED IN THE REPORT, THE 10 MILLION THAT WILL BE COMING DOWN TO SAN FRANCISCO IS JUST A SMALL PART OF THE MENTAL HEALTH FUNDING COMPARED TO THE 2200 MILLION THAT THE CITY HAS.

AND I HOPE THAT THIS PROCESS WOULD INITIATE SYSTEMS CHANGE IN THE DELIVERY OF MENTAL HEALTH SERVICES TO SAN FRANCISCO.

WHAT I'D LIKE TO POINT OUT THOUGH IS THAT THE API COMMUNITY IS NOT REPRESENTED IN THE TRANSITIONAL AGE POPULATION. THE WORD IMMIGRANT DOES NOT ADEQUATELY REPRESENT THE API YOUTH -- TRANSITIONAL YOUTH COMMUNITY.

THE GROUP THAT I REPRESENT DID A STUDY IN REGARDS TO THE ISSUES AND CONCERNS OF API YOUTH, AND VIOLENCE IS TOP ON THE LIST, PARTICULARLY VICTIMIZATION OF OUR YOUNG PEOPLE.

WE SURVEYED 300 YOUNG PEOPLE, AND 100% OF THE YOUNG PEOPLE THAT WE SURVEYED EXPRESSED BEING VICTIMS OF, WITNESSING, AND BEING PERPETRATORS OF VIOLENCE IN ONE WEEK.

THOSE 300 YOUNG PEOPLE SAW OR EXPERIENCED VIOLENCE, ON THEIR WAY TO SCHOOL OR COMING HOME FROM SCHOOL.

AND I THINK IT'S A VERY VALID ISSUE OF THE API YOUTH COMMUNITY.

ANOTHER PART OF -- ANOTHER THING I WANTED TO BRING UP WAS TO HAVE COALITIONS AND CONSORTIUMS AND GROUPS IN THE RESPECTIVE COMMUNITY TO BE INVOLVED IN THIS PROCESS.

I KNOW IT'S RECOGNIZED THAT THE  
LATINO COMMUNITY COALITIONS HAVE  
BEEN IDENTIFIED IN PARTICIPATING  
IN THIS PROCESS.  
I THINK THAT OUR GROUP, THE  
ASIAN YOUTH -- ASIAN PACIFIC  
ISLAND YOUTH ADVOCACY NETWORK  
CAN PARTICIPATE IN THIS PROCESS  
AND WOULD LIKE TO PARTICIPATE IN  
THIS PROCESS.  
BUT OVERALL, I THINK THE  
DOCUMENT'S GOOD.  
JUST THAT ONE POINT, THAT  
IMMIGRANT DOES NOT REPRESENT THE  
API POPULATION.  
THANK YOU.  
>> Board Member Wilson: THANK  
YOU.  
>> (APPLAUSE.)  
>> Board Member Wilson: I WILL  
CALL THE NEXT THREE SPEAKERS.  
PLEASE, STATE YOUR FIRST AND  
LAST NAME, BECAUSE I MIGHT MESS  
IT UP.  
THANK YOU VERY MUCH.  
LAURA, ROBERT, AND JAMES.  
LAURA FROM NNRC.  
THANK YOU.  
>> HELLO.  
LAURA GUZMAN, FROM THE CENTER.  
I WANT TO THANK EVERYBODY THAT  
PARTICIPATED IN THE WRITING OF  
THIS PLAN.  
IT WAS -- PARTICIPATING IN THE  
COMMITTEES, SPECIFICALLY IN THE  
CULTURAL -- AND I WANT TO  
HIGHLIGHT TWO THINGS ABOUT THE  
PLAN THAT I THINK NEEDS TO BE  
TAKEN INTO ACCOUNT.  
ONE IS -- AND I AGREE WITH THE  
MENTAL HEALTH ASSOCIATION.  
THE PLAN REALLY HAS A GROSS  
UNDERESTIMATION OF NEEDS, IN  
PARTICULAR OF THAT OF THE  
HOMELESS POPULATION.  
THE PLAN HAS TAKEN INTO ACCOUNT  
THE LAST HOMELESS COUNT OF THE  
CITY, WHICH IS STILL ACTUALLY  
THE COALITION OF HOMELESS IS  
ANOTHER GROUP THAT IS

CHALLENGING, IT'S NOT AN  
ADEQUATE NUMBER.

WE KNOW WE HAVE MORE THAN 6,000  
PEOPLE LIVING HOMELESS IN  
SAN FRANCISCO.

THEREFORE THE ESTIMATION OF NEED  
OF HALF OF THAT POPULATION OF  
3400 PEOPLE WILL BE A GROSS  
UNDERESTIMATION OF NEEDS.

A DROP IN THE CENTER OF THE  
MISSION WHERE WE RECEIVE 250  
PEOPLE EVERY DAY AND THE  
MAJORITY ARE LIVING WITH MENTAL  
ILLNESS AND THAT'S JUST IN THE  
MISSION DISTRICT.

IT'S IMPORTANT THAT YOU CHECK  
THE ESTIMATION OF YOUR NEEDS IN  
THE PLAN.

YOU HAVE A TOTAL LACK OF THE  
NUMBER OF MENTALLY ILL  
IMMIGRANTS IN THE CITY.

I DID RESEARCH MYSELF TO GET --  
AND BOTH -- IN THE CITY OF  
SAN FRANCISCO, WHILE THE  
INCIDENTS OF MENTAL ILLNESS IN  
LATINO IMMIGRANTS.

THE SECOND PIECE OF PLAN I THINK  
DID A GREAT JOB IN DESCRIBING  
THE LACK OF CULTURE LINGUISTIC  
INCOMPETENCY WITH REGARDS TO  
IMMIGRANTS AND AFRICAN-AMERICANS  
WHO ARE HIGHLY SERVED.

BUT I REALLY FEEL THE  
RECOMMENDATIONS -- TO  
UNDERSTANDING OF NEEDS.

THERE ARE ZERO DOLLARS IN THIS  
PLAN TO INITIALLY ADDRESS THE  
NEEDS OF LATINO ADULTS LIVING  
WITH MENTAL ILLNESS IN SPITE OF  
THE FACT THE PLAN'S PAGES TALKS  
ABOUT HOW LATINOS ARE  
UNDERESTIMATED.

I THINK THAT'S -- WHAT WAS  
UNDERSTOOD OF THE NEED.

I THINK THAT THAT IS SOMETHING  
THAT NEEDS TO BE REALLY  
RECONSIDERED.

PERSONALLY, -- 200,000 FOR TWO  
YEARS TO SERVE 75 LATINO  
IMMIGRANTS WHO ARE HOMELESS SO



IT TAKES ABOUT 200,000 TO GET AT  
LEAST TWO FULL TIME STAFF THAT  
WILL ADDRESS THE NEEDS OF PEOPLE  
WITH SERIOUS MENTAL ILLNESS.  
WE KNOW THE MATH DOESN'T WORK.  
IF YOU WOULD READ THE PLAN,  
THERE IS A IN CONGRUENCY ABOUT  
THE NEED.

LOOKING INTO THAT WILL BE  
IMPORTANT.

OTHERWISE WE ARE PARTNERS, AND  
THANK YOU VERY MUCH FOR YOUR  
WORK.

>> Board Member Wilson: THANK  
YOU VERY MUCH.

ROBERT CHOLA.

STATE YOUR FIRST AND LAST NAME  
AGAIN, IN CASE I MESSED IT UP.

>> I AM ROBERT, CASE MANAGER AT  
SURVIVORS INTERNATIONAL IN  
SAN FRANCISCO.

FOR OVER 15 YEARS WE'VE SERVED  
SURVIVORS OF TORTURE AND GENDER  
BASED VIOLENCE WITH SOCIAL  
SERVICES.

I'M HERE TO CALL UPON YOU TO  
ADDRESS THESE SURVIVORS AS  
STAKEHOLDERS IN THIS PROCESS.  
UNDER THE RUBRIC OF TRAUMA TO  
ADDRESS SPECIFIC NEEDS AND TAKE  
STEPS TO -- TOWARDS THE GOALS OF  
OUTREACH, COMBATTING STIGMA AND  
CULTURAL COMPETENCE.

SURVIVORS OF TORTURE REPRESENT A  
LARGE PORTION OF THE IMMIGRANT  
POPULATION OF SAN FRANCISCO AND  
A LARGE PORTION OF THE  
POPULATION OF THE UNITED STATES.  
WITH OVER 400,000 TORTURE  
SURVIVORS IDENTIFIED BY THE  
CONGRESS, WITH OVER 8,000  
SUPPOSEDLY IN CALIFORNIA, WITH  
15,000 REFUGEES IN  
SAN FRANCISCO, IT'S NO QUESTION  
THAT SURVIVORS OF TORTURE  
REPRESENT A HUGE ISSUE IN  
SAN FRANCISCO.

WITH GUATEMALAN AND OTHERS, THE  
NEEDS COME OUT AS NEEDING FOR  
SERVICES AROUND MAJOR DEPRESSION

AND OTHER MAJOR MENTAL ISSUES WHO HAVE BEEN VICTIMS OF TORTURE.

OUR ORGANIZATION HAS SERVED THESE TORTURE SURVIVORS FOR OVER 15 YEARS AND PROVIDED TRAINING AND CULTURAL COMPETENCE CONSULTING TO MANY OTHER ORGANIZATIONS AND WE ARE WILLING TO PUT OURSELVES FORWARD FOR THIS KIND OF WORK BUT WE NEED TO BE ADDRESSED -- OR WE NEED THE TORTURE SURVIVORS TO BE ADDRESSED WITHIN THIS PROCESS. MANY OF OUR CLIENTS HAVE COME FACE TO FACE WITH THE COUNTY MENTAL HEALTH SYSTEM AND FOUND THEIR NEEDS WERE NOT ADDRESSED IN THE PROPER WAYS. THEY ENDED UP IN EMERGENCY ROOMS WITH THEIR NIGHTMARES AND FLASHBACKS BEING TREATED WITH MEDICATION.

SOME NEVER TOUCH THE SYSTEM AND COME TO US THROUGH OTHER VENUES, WHICH IS AN OPPORTUNITY FOR THE MENTAL HEALTH SERVICE ACT TO ADDRESS OTHER ISSUES.

MANY OF OUR CLIENTS COME THROUGH LEGAL CBO's, OTHER ORGANIZATIONS AND COMMUNITY BASED ORGANIZATIONS WHERE THEY'RE COMING TO ADDRESS FIRST THEIR IMMIGRATION ISSUE, BUT WITH THAT COMES ADDRESSING THE ISSUE OF THEIR PSYCHOLOGICAL TREATMENT.

WE HAVE A HISTORY OF PROVIDING LINGUISTIC AND CULTURAL COMPETENCY TO OUR CLIENTS WITH OUR CLINICIANS COMING FROM THE AFFECTED COMMUNITIES AROUND THE GLOBE.

WE ARE WILLING TO PUT FORWARD THIS KIND OF WORK AND EFFORT TO ADDRESS THESE ISSUES TO PROVIDE THE KIND OF TRAINING NECESSARY THAT WILL PROVIDE BETTER OUTREACH, BETTER UNDERSTANDING OF CULTURAL COMPETENCE AND

BETTER COMBATting THE STIGMA OF  
MENTAL HEALTH AND BETTER SERVE  
THE COMMUNITY WHICH HAS LONG  
BEEN INVISIBLE AND SILENTLY  
SUFFERING IN SAN FRANCISCO.

>> Board Member Wilson: THANK  
YOU.

JAMES CANISH.

>> MY NAME IS JAMES, WITH THE  
COALITION ON HOMELESSNESS.  
THANKS FOR THE OPPORTUNITY TO  
SPEAK.

OVERALL, I THINK THE  
RECOMMENDATIONS SET FORWARD ARE  
VERY GOOD AND THE PLAN IS GOOD,  
ESPECIALLY THE 24 HOUR CRISIS  
CENTER THAT YOU ALL RECOMMENDED,  
AND THAT'S AN IMPORTANT ONE.  
ONE THING WE WOULD LIKE TO SEE  
WITH THAT IS INSURE THAT IT IS  
CONSUMER DRIVEN AND CONSUMER  
INCLUSIVE.

ONE GLARING ASPECT OF THIS PLAN,  
WHICH SORT OF JUMPS OUT, AND IT  
WAS MENTIONED EARLIER, THE  
NOTICEABLE ABSENCE OF ANY SORT  
OF PATIENTS RIGHTS COMPONENT.  
THE ESSENCE OF THIS -- THE  
VISIONARY SPIRIT AND THE THINGS  
BEHIND THE MENTAL HEALTH  
SERVICES ACT IS THAT IT'S GOING  
TO TRANSFORM THE MENTAL HEALTH  
SYSTEM.

SO AN IMPORTANT PART OF LEADING  
TO THIS TRANSFORMATION IS  
INCLUDING THE CONSUMER VOICE.  
AND YOU DID THAT WHEN YOU HAD  
THE TASK FORCE MEETINGS AND  
COMMUNITY MEETINGS.

YOU REALLY MADE AGGRESSIVE  
OUTREACH FOR CONSUMERS AND THAT  
IS GREAT AND YOU DESERVE TO BE  
APPLAUDED.

BUT IT SHOULDN'T STOP THERE AND  
CONTINUE ON.

AND THAT IS IN IMPLEMENTING IT,  
THERE'S NO GRIEVANCE OR  
PROBLEM-SOLVING MECHANISM AND  
THIS DOES RELATE TO  
IMPLEMENTATION.

CONSUMERS NEED A WAY TO COMPRESSES THEIR DISSATISFACTION IN THE EVENT THEY WANT TO FILE A GRIEVANCE, IF THEY FEEL THEY'RE DISSERVED, IF THEY FEEL THE SERVICES THEY RECEIVED WERE NOT THE BEST THAT THEY COULD. THEY HAVE VALUABLE PERSPECTIVES THAT SHOULD BE INCLUDED, AND FOR A FULL, FULL SERVICE PARTNERSHIP, YOU NEED TO HAVE A STRUCTURAL PLATFORM OF DIALOGUE FOR PROBLEM-SOLVING AND CONFLICT RESOLUTION.

THE CURRENT MENTAL HEALTH SYSTEM IS VERY DISEMPOWERING FOR MENTAL HEALTH CONSUMERS.

I SAY THAT AS A FORMER MENTAL HEALTH CONSUMER AND AS AN ADVOCATE.

HOW TRANSFORMATIVE DO YOU WANT IT TO BE?

DO YOU WANT TO SAY HERE'S 5 MILLION.

OR DO YOU WANT TO GET TO THE ESSENCE, THE BACKGROUND OF THE DIFFERENCE BETWEEN US AND THEM. THE CONSUMERS AND CLIENTS ARE NOT THE OTHER.

THEY NEED TO BE INCORPORATED RIGHT IN WITH ALL OF THIS.

SO THAT'S MY MAIN THING.

TAKE THEIR CONCERNS SERIOUSLY. TAKE THEIR GRIEVANCES SERIOUSLY. IT WAS DISHEARTENING THAT THE MOBILE CRISIS MONEY WAS LEFT OUT.

EVEN LIKE EXPANDING A DIFFERENT FORM OF MOBILE CRISIS, RIGHT. BECAUSE THAT IS VERY IMPORTANT FIRST RESPONDER AND INITIAL WAY TO ADDRESS THIS.

AND WOULD ALWAYS LIKE TO SEE MORE MONEY GOING IN FOR MEDI-CAL, ADVOCACY FOR LINKAGE LIKE SSI AND FEDERAL ENTITLEMENT PROGRAMS TO DRAW MONEY FROM OUTSIDE.

OVERALL YOU DID A GREAT JOB IN A VERY ARDUOUS TASK IT WAS.

THANKS.

>> (APPLAUSE.)

>> Board Member Wilson: THANK YOU.

FOR PEOPLE WHO HAVE JUST COME IN, IF YOU WANT TO FILL OUT A CARD TO MAKE PUBLIC COMMENT, PLEASE FEEL FREE TO DO SO. RICH SNOWDEN WILL BE GLAD TO GIVE YOU A CARD.

>> Board Member Wilson: OUR NEXT THREE SPEAKERS, PHIL, MICHELLE, C. W. JOHNSON. AGAIN, IF YOU CAN REPEAT YOUR NAME.

>> MY NAME IS PHIL WINEBO, I'M A RETIRED CITY EMPLOYEE.

MY LAST EMPLOYER WAS COMMUNITY MENTAL HEALTH.

I WORKED THERE IN THE LATTER PART OF 1986, WHEN THEY WERE LOCATED AT 555 POLK.

MY GOOD FRIEND, TERRY, CALLED IT TRIPLE NICKEL.

AND THEN WE MOVED OVER TO 1380 HOWARD STREET.

I WAS A DRIVER TO DIFFERENT HALFWAY HOUSES, DAY CARE CENTERS, AND MANY OTHER OFFICES, INCLUDING PROGRESS FOUNDATION OFFICES, AND CONNARD HOUSE OFFICES.

AND I HAVE BEEN A CONSUMER IN THE PAST TOO.

AND IT'S REALLY ROUGH TO SEE SOME PEOPLE HOMELESS.

AT ONE TIME I WAS WALKING DOWN MARKET STREET AFTER A WEST BAY RETIREE MEETING, AND I SAW A WOMAN UNCONSCIOUS, PARTLY FROM FATIGUE, AND A LITTLE POOL OF BLOOD THERE.

AND A GUY WAS SLEEPING ON THE SLEEPING BAG.

AND I DIDN'T KNOW WHAT TO DO ABOUT IT.

SO I THINK THE SUBJECT IS VERY IMPORTANT, AND NEEDS TO BE ADDRESSED MORE.

AND I'VE BEEN TO THE LAST TWO

MEETINGS OF COMMUNITY MENTAL  
HEALTH.

ONE, ABOUT SEVEN OR EIGHT WEEKS  
AGO AT CITY HALL, IN ROOM -- I  
BELIEVE IT WAS 400, AND THEN THE  
SECOND WEDNESDAY OF THIS MONTH  
AT 1380 HOWARD, THE FIFTH FLOOR.  
AND I'M GOING TO TRY TO MAKE  
THAT COMMUNITY MENTAL HEALTH  
MEETING EVERY MONTH FROM NOW ON.  
AND THAT'S ABOUT ALL I CAN ADD.  
BUT I USED TO WORK IN THE MAIL  
ROOM, SENDING OUT FORMS.  
AND I WAS AMAZED AT ALL THE  
FORMS THERE WERE.

AND SOME OF THEM WERE SIX OR  
SEVEN FEET HIGH, AT 555 POLK.  
AND IT WAS -- WE HAD MORE ROOM  
OVER AT 1380 HOWARD.  
AND THAT'S ABOUT IT.  
THANK YOU.

>> Board Member Wilson: THANK  
YOU.

MICHELLE SHOALTS.

>> GOOD AFTERNOON.

THANK YOU FOR ALLOWING ME TO  
SPEAK TODAY AND THE PUBLIC  
TESTIMONY.

AND THE PREVIOUS SPEAKERS FROM  
THE COMMUNITY AND CONSUMERS HAVE  
SPOKEN VERY ELOQUENTLY ABOUT  
THINGS THAT ARE NEEDED.

AND I'M SPEAKING TODAY AS A  
CONSUMER WORKING WITH THE MENTAL  
HEALTH ASSOCIATION OF  
SAN FRANCISCO, AND THEY HAVE  
DIFFERENT PROGRAMS.

AND I'M HERE TO SAY THAT THANK  
GOD THAT THEY'RE THERE WITH  
THESE PROGRAMS.

AND I DON'T THINK ANY SHOULD BE  
ELIMINATED.

AND PERHAPS SOME OF THE PROGRAMS  
HAVEN'T -- AREN'T EVEN LISTED AS  
RECEIVING MONEY.

FOR EXAMPLE, HORDING AND  
CLUTTERING, WHICH HAS PEOPLE  
WITH A SPECIFIC PROBLEM.

THEIR BRAINS WORK A LITTLE BIT  
DIFFERENTLY.

AND THEY THINK A LITTLE BIT DIFFERENTLY.

AND IT'S MAYBE A SILENT KIND OF MAJORITY, BUT THE MENENHOF ASSOCIATION HAS MEETING GROUPS FOR THESE PEOPLE.

AND TO BE -- PEER GROUPS I GUESS YOU WOULD CALL THEM, ARE VERY IMPORTANT ON ANY LEVEL, BECAUSE PEOPLE FEEL -- THEN THEY'RE NOT ISOLATED AND THEY'RE WITH OTHER PEOPLE JUST LIKE THEM WHO UNDERSTAND.

BECAUSE THERE'S A LOT OF PEOPLE, INCLUDING CAREGIVERS, THAT JUST DON'T GET IT ABOUT CERTAIN DISORDERS.

AND I'M SO GLAD THAT THE PROPOSITION PASSED.

AND I'M SORRY TO HEAR THAT THERE'S NOT ENOUGH FUNDING. FOR EXAMPLE, IF I WON THE LOTTERY, I'D DONATE A LOT OF MONEY TO MENTAL HEALTH. IT'S REALLY IMPORTANT. THANK YOU VERY MUCH.

>> Board Member Wilson: THANK YOU.

C. W. JOHNSON.  
>> HELLO.

MY NAME IS C. W. JOHNSON A CONSUMER FOR MENTAL HEALTH. I NOTICE YOU GUYS HAVE SOME MONEY FOR HOUSING.

AND I THINK THAT I NOTICED THAT HOUSING IS A PHYSICAL MEANS OF A ROOM AND BATHROOM, AND THAT SEEMS TO BE JUST ABOUT IT. I'D LIKE TO SEE SOME OF THAT MONEY GO TOWARD APARTMENT INITIATIVES AND SUPPORTIVE HOUSING WHERE PEOPLE -- MAYBE SOCIAL WORKERS COMING ON TO THE PREMISES, LIKE A REAL APARTMENT. BECAUSE AS YOU GROW AS A CONSUMER, AS YOU GET MORE STABILIZED, YOU WANT MORE THINGS.

SECOND, I WOULD LIKE TO SEE MORE EDUCATION TO HELP CONSUMERS TO



BECOME MORE FUNCTIONAL  
EDUCATIONAL-WISE.  
MY MAIN GOAL IS TO BECOME --  
EVENTUALLY BECOME A THERAPIST.  
RIGHT NOW I'M DOING PEER  
COUNSELING, AND I HAVE DONE  
OUTREACH AND STUFF IN THE PAST.  
MY ULTIMATE GOAL IS TO HELP  
PEOPLE THAT ARE LIKE MYSELF.  
I WOULD LIKE TO SEE SOME MONEY  
GO TOWARD EDUCATION, MAYBE  
GIVING INITIATIVE TO MAKE PEOPLE  
WANT TO GO BACK TO WORK OR GO  
BACK TO SCHOOL.  
THOSE ARE SOME OF THE THINGS I'D  
LIKE TO SEE.  
THE THIRD THING I THINK I REALLY  
WOULD LIKE TO SEE, IF FAMILIES  
SEEM TO HAVE KIDS THAT HAVE  
DISABILITIES AND STUFF, TO BE  
MORE PARENT AWARENESS.  
PARENTS SEEM TO BE SOMEWHAT IN  
THE DARK ABOUT A LOT OF THINGS  
ABOUT MENTAL HEALTH.  
I WOULD LIKE TO SEE MENTAL  
HEALTH EDUCATION FOR PARENTS  
WITH DISABLED KIDS LIKE MYSELF.  
MY PARENTS HAD NO CLUE THAT I  
WAS DISABLED OR WHAT WAS WRONG  
WITH ME.  
I WOULD LIKE TO SEE SOME  
EDUCATIONAL AWARENESS FOR  
PARENTS.  
SO THANK YOU VERY MUCH.  
>> Board Member Wilson: THANK  
YOU.  
>> (APPLAUSE.)  
>> Board Member Wilson:  
SPEAKER ANDREA SAGET.  
>> HELLO.  
MY NAME IS ANDREA SAGET.  
I WORK FOR CONSUMER DEVELOPMENT  
AND WE PRIMARILY DO SUBSTANCE  
ABUSE PROGRAMMING IN SCHOOLS FOR  
ADOLESCENTS.  
OFTEN WE WORK AT CONTINUATION  
AND COUNTY COMMUNITY SCHOOLS.  
I WANTED TO UNDERSCORE THE  
CONSEQUENCE OF VIOLENCE THAT  
PLAGUE MANY NEIGHBORHOODS IN

SAN FRANCISCO.  
SO MANY OF OUR KIDS SEE VIOLENCE  
ALL THE TIME.

AND EACH THOUGH MY PROGRAM IS A  
SUBSTANCE ABUSE PREVENTION  
PROGRAM, WHAT WE DO IS ALSO  
MENTAL HEALTH PREVENTION.  
AND JUST VERY QUICKLY, A  
COUPLE -- AND I COMMEND THE PLAN  
AND EVERYONE WHO PARTICIPATED IN  
DEVELOPING THIS PLAN.

IT WAS A VERY OPEN PROCESS OF  
PARTICIPATION.

AND A COUPLE OF THINGS THAT I  
HAVEN'T HEARD TALKED ABOUT, AND  
I THINK NEED TO BE INCLUDED IN  
ANY OF THE PREVENTION EFFORTS  
THAT ARE UNDERTAKEN WITH THIS  
PLAN, IS LOOKING AT EMPLOYMENT  
FOR YOUNG FOLKS, AND ALSO WHICH  
I THINK THIS HAS BEEN MENTIONED  
IS THE ISSUE OF HOMELESSNESS.  
YOUNG PEOPLE WHO DON'T HAVE  
HOMES HAVE A REALLY HARD TIME  
DOING MUCH ELSE, INCLUDING  
SUCCEEDING ACADEMICALLY, AND  
BEING ABLE TO FIND OR TRAIN FOR  
EMPLOYMENT.

AND WE REALLY NEED TO LOOK AT  
THIS ESPECIALLY -- WELL ALL  
FOLKS BUT MY EXPERIENCE IS WITH  
YOUTH, IN A VERY HOLEIFIC WAY.  
HOW ARE WE SUPPORTING THEM, HOW  
ARE WE HELPING THEM BUILD  
RELATIONSHIPS.

WE NEED TO MAKE SURE THAT THE  
PROGRAMS THAT WE ROLL OUT WITH  
THIS PLAN AND REALLY ADDRESS  
THESE POINTS.

THANK YOU.

>> (APPLAUSE.)

>> Board Member Wilson: THANK  
YOU.

NEXT SPEAKER, RICHARD ARMEED.  
IS RICHARD ARMEED HERE?  
HOW ABOUT VERA HIDAL.

>> IS THIS THE MICROPHONE?

I JUST GOT HERE.

I THOUGHT I WOULD HAVE A FEW  
SECONDS.

AN ASSOCIATE OF MINE SPOKE AND I WASN'T HERE TO LISTEN TO WHAT HE SAID.

I JUST HAVE A FEW THINGS TO SAY ABOUT A PROPOSAL THAT WE SUBMITTED, THAT FOCUSED ON BIPOLAR.

WE CROSSED THE PARAMETER OF AGE, SEX, AND INCLUDED ALL THOSE WHO HAD SERIOUS BIPOLAR OR DEPRESSIVE CONDITIONS.

TALKED ABOUT THE MILLIONS OF DOLLARS LOST IN BUSINESS HOURS, IN CORPORATE HOURS.

AND WE HAD EMPHASIZED PEER TO PEER RELATIONSHIP, AND WE OF COURSE WERE TALKING ABOUT A MENTAL HEALTH RESOURCE CENTER, THAT WE FELT, AS AMONG THOSE WHO HAVE SUFFERED THE ILLNESS, IN CONJUNCTION WITH THE DBSA, THE DEPRESSIVE BIPOLAR SUPPORT LINES, WE FELT WE COULD DO EXCEPTIONAL THINGS IN AREAS SUCH AS VOCATIONAL ADJUSTMENT AND OTHER AREAS.

UNDERSTANDING THAT THOSE WHO ARE SERIOUSLY ILL WOULD NEED MEDICAL ATTENTION, BUT WE WEREN'T IN THE POSITION TO GIVE, BUT WE WOULD HAVE A REPRESENTATIVE.

AND MY MAIN COMMENT IS THAT WE WERE VERY DISAPPOINTED THAT THERE WAS NO MENTION OF OUR PROPOSAL, WHICH WE THOUGHT AND HAD REASON TO BELIEVE WAS COMPREHENSIVE, AND INCLUDED MEASURABLE QUALITIES, AND WAS A COLLABORATION WITH AN ORGANIZATION, DBSA, WHICH HAS PROVED, WE THINK, HAS A TRACK RECORD OF WORKING WITH PEOPLE WHO COME BACK AND COME BACK, AND HAVE MADE IMPROVEMENTS.

SO I GUESS MAINLY THE POINT IS THAT WE FEEL THAT WHAT HAS BEEN SUGGESTED DOES NOT DEAL WITH DEPRESSIVE AND BIPOLAR PEOPLE, WHO WE TEND TO BELIEVE ARE 69,000 PEOPLE IN SAN FRANCISCO.

AND WE FELT THAT THERE WAS AN EXTRAORDINARY EMPHASIS ON ITEMS SUCH AS AGE, ETHNICITY, WHICH WE UNDERSTAND ARE POLITICALLY CORRECT, BUT WE DIDN'T FEEL REALLY ADDRESSED THE PROBLEM THAT WE FELT WE ADDRESSED. THAT'S ALL I HAVE TO SAY.

WE HOPE THAT THERE WILL BE A CHANCE TO RECONSIDER IT.

>> Board Member Wilson: THANK YOU.

VERA.

>> I AM VERA HALE, AND I WAS A MEMBER OF THE TASK FORCE. DURING THE PROCESS WAS ONE OF THE COCHAIRS OF THE OLDER ADULTS SUBCOMMITTEE, ALONG WITH MIKE MEDEMA.

I WANTED TO TELL YOU A COUPLE OF THINGS.

ONE IS WE WERE VERY PLEASED TO SEE THAT THE COUNTY ACKNOWLEDGED THAT OLDER ADULTS ARE AN UNDERSERVED POPULATION, AND THAT THEY HAVE BEEN DIFFICULT TO REACH, THERE ARE MORE PEOPLE OUT THERE NEEDING TREATMENT THAN ARE GETTING IT, AND IT IS VERY DIFFICULT FOR THE SYSTEM TO RESPOND APPROPRIATELY TO THEM.

DURING OUR MANY MEETINGS WITH OUR SUBCOMMITTEE, WE HAD MANY PEOPLE FROM AGING AND CONSUMERS WHO BROUGHT US IDEAS.

AND WE HAD A LOT MORE IDEAS OF COURSE THAT END UP IN THE FINAL PROPOSAL.

BUT WE WERE PLEASED, THIS FINAL PROPOSAL CAME UP WITH A NEW IDEA FOR A SENIOR RECOVERY CENTER.

AND AS A WAY TO INVOLVE PEOPLE IN THE COMMUNITY AND TO WORK WITH SOME OF THE AGING SENIOR CENTERS, AS WELL AS GETTING MENTAL HEALTH CLOSER TO WHERE SENIORS ACTUALLY ARE.

WE DO HOPE, HOWEVER, IN THE PROPOSAL THERE DESCRIBED AS SEPARATE, THE PART WORKING WITH

PRIMARY CARE, AND THE PART WITH SENIOR RECOVERY CENTER. AND WE WOULD LIKE TO SEE THESE TWO WORK CLOSELY TOGETHER, BECAUSE OFTEN ELDERLY, WHO MAY HAVE MENTAL PROBLEMS MAY NOT THINK ABOUT IT BUT STILL WILL BE WILLING TO GO TO A PRIMARY CARE PHYSICIAN.

AND OFTEN, THEY HAVE BEEN RECENTLY.

SO WE THINK IT'S VERY IMPORTANT TO HAVE THAT TIE, AND WILL STRENGTHEN THE SERVICES OF THE RECOVERY CENTER, AS WELL AS THE PRIMARY CARE PORTION OF GREATER MENTAL HEALTH FOR SENIORS.

>> Board Member Wilson: THANK YOU.

>> Chair Turner: I'M WONDERING IF THERE ARE ANY OTHER MEMBERS OF THE PUBLIC WHO HAVE NOT SPOKEN, WHO WOULD LIKE TO MAKE COMMENTS.

SEEING NONE -- YES, I DO SEE SOMEONE.

WILL YOU STATE YOUR NAME AT THE BEGINNING, AND THEN LET RICH SNOWDEN HAVE YOUR CARD WHEN YOU'RE DONE.

>> HI.

MY NAME IS JANET SHALWITS, A YOUTH ADVOCATE AND A PRIMARY CARE PROVIDER AND ADOLESCENT CARE SPECIALIST AND A PROFESS AT UCSF.

THIS HAS BEEN A GREAT PROCESS. I PARTICIPATED IN TWO OF THE SUBCOMMITTEES, THE CHILDREN AND YOUTH SUBCOMMITTEE AND TRANSITIONAL YOUTH, AND THE BREADTH OF THE CONVERSATION AND DISCUSSION WAS WONDERFUL AND STIMULATING.

AND I THINK THAT THERE IS LOTS OF OPPORTUNITY FOR US TO BE ON THE CUTTING EDGE OF AMAZING THINGS HERE IN SAN FRANCISCO. THE THING THAT I HAVE TO SAY, THAT I THINK HAS BEEN REITERATED

MANY TIMES BEFORE, IS THE ISSUE OF TRANSFORMATION.

RIGHT NOW, IT HAS BEEN STATED BY THE HEALTH COMMISSION, AS WELL AS BY THE HEALTH DEPARTMENT, THAT 99.4% OF CHILDREN ARE COVERED BY HEALTH INSURANCE IN SAN FRANCISCO.

THAT'S EXTRAORDINARY.

AND MANY OF THOSE CHILDREN HAVE -- SHOULD HAVE ACCESS TO THE MENTAL HEALTH SYSTEM THROUGH THEIR PUBLIC HEALTH INSURANCE. THE HEALTH DEPARTMENT IS THE PROVIDER OF MENTAL HEALTH CARE FOR ALL KIDS WHO ARE RECEIVING MEDI-CAL, FOR MANY OF THE KIDS WHO RECEIVE HEALTHY FAMILIES AND THOSE WHO RECEIVE HEALTHY KIDS AND YOUNG ADULTS.

THAT COMPRISES MANY YOUNG PEOPLE AND MANY ARE NOT ABLE TO ACCESS SERVICES AND THE SERVICES THEY RECEIVE ARE SUBPAR.

WE HAVE AN OPPORTUNITY HERE NOT ONLY TO CREATE NOVEL CUTTING-EDGE PROGRAMS THAT STAND ALONE, AS THEY SHOULD NOT BE, BUT TO REALLY CREATE A SYSTEM WHEREBY EVERY SINGLE YOUNG PERSON, WHO SELF-REFERS, WHO IS REFERRED BY FAMILIES, WHO IS REFERRED BY PROVIDERS, RECEIVES EXCELLENT CARE THAT IS AGE APPROPRIATE, THAT'S DEVELOPMENTALLY APPROPRIATE, CULTURALLY APPROPRIATE, AND MEETS THEIR NEEDS.

AND IT IS NOT THE 45 MINUTE HOUR THAT IS INAPPROPRIATE FOR THE CARE OF A CHILD.

SO I THINK WE HAVE A GREAT CHALLENGE HERE TO REALLY STEP UP TO THE PLATE, AND CREATE A SYSTEM THAT IS RESPONSIVE TO THE NEEDS OF THE MANY CARING PEOPLE IN THE COMMUNITY WHO HAVE COME FORWARD AND WHO WOULD LIKE THEIR IDEAS -- THE EVIDENCE FROM THE LITERATURE, EVERYTHING THAT WE

KNOW, TO COME TOGETHER, SO THAT WE AGAIN CREATE A SYSTEM THAT MAKES SENSE FOR HUMAN BEINGS. AND FOR ALL HUMAN BEINGS, NOT JUST THE FEW WHO WILL ACCESS THE NEW NOVEL PROGRAMS THAT WILL BE DEVELOPED WITH THIS NEW MONEY. THANKS.

>> Board Member Wilson: THANK YOU.

>> (APPLAUSE.)

>> Chair Turner: ARE THERE ANY OTHER MEMBERS OF THE PUBLIC WHO WOULD LIKE TO MAKE COMMENTS?

I'M RELUCTANT TO CLOSE THE PUBLIC COMMENT PORTION AT THIS TIME, BECAUSE SOME INDIVIDUALS HAVE STATED THEY WILL BE COMING AFTER WORK.

WHAT WE'RE GOING TO DO IS WE'RE GOING TO TAKE A 10 MINUTE RECESS.

AND WE ARE GOING TO COME BACK AT THAT TIME.

AND IF THERE'S STILL NO ONE WHO WANTS TO COMMENT AT THAT TIME, WE'RE GOING TO CLOSE PUBLIC COMMENT, AND THE BOARD WILL HAVE RECONVENED OUR DELIBERATIONS.

SO WE'LL START AND TAKE ABOUT 10 MINUTES.  
THANK YOU.

>> -- OF THE PUBLIC WHO WOULD LIKE TO MAKE COMMENTS AT THIS TIME.

OKAY.

SEEING NONE, PUBLIC COMMENT IS CLOSED.

I'D LIKE TO OFFER AN OPPORTUNITY FOR BARBARA GARCA, DEPUTY DIRECTOR OF HEALTH, THE PERSON WHO HAS BEEN THE CHAIR OF THE BEHAVIORAL CENTERS TASK FORCE.

I'D LIKE TO GIVE HER AN OPPORTUNITY TO MAKE A COMMENT AT THIS TIME.

>> [NO AUDIO.] OF THE PLAN FOR US.

AS MANY OF YOU KNOW, AND WE HAD SEVERAL MEMBERS OF THE MENTAL HEALTH BOARD ON THE TASK FORCE, YOUR ROLE IS ESSENTIAL IN THIS PROCESS, AND YOU WERE ASKED TO PROVIDE PUBLIC HEARING, TO HOLD PUBLIC HEARINGS FOR THE COMMUNITY AT LARGE TO INSURE THAT WE HAD AS MUCH INFORMATION AS POSSIBLE FROM THE COMMUNITY. SO I REALLY WANT TO THANK ALL OF YOU FOR ALL YOUR WORK IN THE LAST COUPLE OF DAYS OF PROVIDING THESE HEARINGS.

THIS IS ONLY THE BEGINNING. WE HAVE NOW AN APPLICATION TO THE STATE THAT WE'RE GOING TO TAKE THESE COMMENTS FROM MANY OF THE INDIVIDUALS TODAY. AND I WANTED TO THANK THE CONSUMERS AND INDIVIDUALS WHO HAVE TESTIFIED.

THAT'S BEEN THE REAL RICHNESS OF THIS PROCESS, HAS BEEN THE OPEN PROCESS THAT WE ESTABLISHED FOR THIS.

SO THIS IS THE VERY BEGINNING OF THIS PROCESS.

WE NOW HAVE TO GO THROUGH SEVERAL PROCESSES.

WE WILL SUBMIT THIS TO THE STATE, IN THE FIRST WEEK OF NOVEMBER.

AND THEN, FROM THERE TO THE TIME WE HEAR FROM THE STATE, WE WILL PROBABLY HAVE SOME OPEN PROCESSES TO DISCUSS THE PLANS, AND TO DISCUSS THE INITIATIVES, SO THAT WE CAN GET AS MUCH RICH INFORMATION IN THAT PROCESS AND THE DEVELOPMENT OF A PROPOSAL FOR THE COMMUNITY AND PROVIDERS TO APPLY FOR.

SO AGAIN, I WANT TO THANK THE MENTAL HEALTH BOARD AND ALSO THE FACT THAT THIS WILL CONTINUE PROBABLY WE DO ANTICIPATE HAVING SOME KIND OF ACCOUNTABILITY GROUP THAT WOULD WATCH AND ASSIST US IN THE PROCESS AND



IMPLEMENTATION.

WE HAVEN'T WORKED ALL OF THOSE DETAILS OUT YET AND WE HAVEN'T HEARD FROM THE STATE EXACTLY WHAT THEY WOULD BE LOOKING FOR BUT WE ANTICIPATE THEY WILL WANT SOME CONTINUATION OF THE MENTAL HEALTH BOARD INVOLVEMENT AND AN OVERSIGHT GROUP TO CONTINUE WITH THE PROCESS OF THE TRANSFORMATION OF THE MENTAL HEALTH PROCESS IN SAN FRANCISCO. THANK YOU.

>> Chair Turner: THANK YOU.

THE MENTAL HEALTH BOARD I'M SURE WILL BE CONTINUED TO BE INVOLVED IN THIS PROCESS.

THERE ARE MANY STAKEHOLDERS IN MANY WAYS AND WE LOOK FORWARD TO WORKING WITH YOU.

AT THIS POINT, I WOULD LIKE TO GET, FROM BOARD MEMBERS, YOUR RECOMMENDATIONS BASED ON YOUR OWN READING OF THE DRAFT PLAN, AS WELL AS WHAT YOU'VE GATHERED AND WHAT YOU'VE INTERPRETED FROM PUBLIC COMMENT.

SO I'LL CALL ON EACH OF YOU TO MAKE A STATEMENT.

AND I SEE MICHAEL, YOU FIRST.

>> Secretary Medema: I ACTUALLY HAD A POINT OF CLARIFICATION FOR A SECOND.

I THINK -- I MAY NOT -- I MAY BE ALONE, I DON'T KNOW.

I'M WONDERING IF OTHER MEMBERS ARE -- HAVE QUESTIONS OF THE DEPARTMENT BEFORE WE PROCEED WITH THAT, OR IF WE'RE JUST GOING TO MAKE COMMENT AT THIS TIME?

>> Chair Turner: THE PLAN IS TO MAKE COMMENT AT THIS TIME. YES.

>> WILL WE, AT SOME TIME THIS EVENING, BE ABLE TO ASK QUESTIONS OF THE DEPARTMENT?

>> Chair Turner: THAT DEPENDS ON IF THEY ARE WILLING AND AVAILABLE TO DO THAT.

I DON'T KNOW HOW LONG YOU HAD  
PLANNED TO BE HERE.

>> [NO AUDIO.]

>> Chair Turner: OKAY.

LET ME GET PEOPLE'S INITIAL  
COMMENTS FIRST, AND THEN, SINCE  
AT LEAST BARBARA WILL BE HERE  
FOR AT LEAST HALF AN HOUR, WE  
CAN ASK QUESTIONS.

>> THANK YOU.

>> Chair Turner: DID YOU HAVE  
ANY COMMENTS THAT YOU WANTED TO  
MAKE, BASED ON THE PLAN, OR WHAT  
YOU'VE GATHERED FROM PUBLIC  
COMMENT?

>> YES.

BUT BASED ON THE PLAN.

MY COMMENT WAS, TO MAKE SURE  
THAT THEY HAVE CONSUMERS FROM  
THAT FOREFRONT.

WHEN I SAY FOREFRONT, WE'VE BEEN  
THERE A LITTLE BIT, BUT GOING  
BACK THROUGH THE NEXT PROCESS,  
AND THEN THE PROCESS FROM HERE  
OUT, MAKE SURE THAT  
SAN FRANCISCO SPECIFICALLY, HAS  
A TEAM OR HAS SUBCOMMITTEE, IS  
THAT WHAT YOU FORM WHEN YOU WANT  
TO DO SOMETHING ELSE, RIGHT?  
MAYBE FORM A SUBCOMMITTEE, THAT  
CAN BE COMMITTED TO THIS  
PARTICULAR PROP 63 FROM HERE ON  
OUT, THE REST OF THE -- WHEN WE  
GET THE MONEY.

THANK YOU.

>> Chair Turner: THANK YOU.

ANYBODY ELSE?

OKAY.

MICHAEL.

>> Secretary Medema: I'LL TAKE  
THE OPPORTUNITY JUST TO MAKE  
COMMENT FIRST.

MY NAME IS MICHAEL MEDEMA, A  
MEMBER OF THE MENTAL HEALTH  
BOARD.

I ECHO SORT OF WHAT I SAID ON  
SATURDAY, WHICH IS THAT THIS IS  
IN NO WAY THE PERFECT PLAN.  
IT'S THE BEST IN MANY WAYS.  
WE HEARD FROM MANY PEOPLE TODAY,

WHO WERE QUESTIONING WHY THERE ARE CERTAIN PROPOSALS ARE OR WHAT CERTAIN THINGS WERE NOT IN THE PLAN.

AND I THINK THAT PERHAPS, BY -- BARBARA CAN HE CAN UP AND DOWN ON THIS BEFORE SHE LEAVES. BUT ONE OF THE THINGS WE'RE LOOKING AT IS THIS BEING A 10-YEAR PLAN, THAT WHAT WE'RE ALSO TRYING TO REMEMBER IS THAT, WITH -- UNFORTUNATELY WITH THE \$5 MILLION PLAN, WE CAN'T BEGIN TO INCORPORATE EVERYTHING. IT WOULD HAVE BEEN LOVELY, HAD THE STATE SAID WE GOT \$500 MILLION INSTEAD, BUT THAT'S JUST NOT THE CASE.

BUT I JUST HAD A COUPLE OF CONCERNS THAT CAME UP TODAY ESPECIALLY FOR ME, WHICH I CONTINUALLY HEARD PEOPLE TALKING ABOUT PATIENTS RIGHTS ADVOCACY, AND THAT BEING INCORPORATED IN THE PLAN, AND IS THAT -- WHERE IS THAT SPELLED OUT IN THE PLAN, AND IF THAT COULD BE A PART OF OUR ADJUSTMENT TO THE PLAN.

I ALSO HEARD CONCERN WITH REGARD TO THE SENIOR RECOVERY CENTER BEING PARTNERED WITH THE PRIMARY DARE.

AND I'D LIKE TO MAKE SURE THAT THAT'S SPELLED OUT IN THE PLAN, IF -- YOU KNOW, IF WE CAN LINK THOSE TWO IN THE PLAN, SO THAT THEY'RE NOT TWO SEPARATE PARTS OF THE PLAN.

AND THEN I SUSPECT THAT IT'S NOT ABLE TO BE SPELLED OUT IN THE PLAN, BUT THE OTHER THING THAT MIGHT BE NICE TO HEAR FROM THE DEPARTMENT BEFORE, IS THE MONEY THAT'S GOING TO BE USED FOR THE PEER-RUN CENTER, FOR THE CRISIS DROP-IN, AND THE 24/7 WARM LINE, WHY THERE'S NOT SPECIFIC FUNDING IN THE PLAN FOR EXPANSION OF MOBILE CRISIS.

SO THOSE ARE THE THINGS I THINK

THAT -- THE OTHER IS I KNOW THAT ONE OF OUR FELLOW TASK FORCE MEMBERS MADE COMMENT OF THERE BEING A CONSUMER POSITION THAT IS HIGH IN THE DEPARTMENT, AND THAT THAT BE SPELLED OUT IN THE PLAN.

AND I WAS A LITTLE CONCERNED ON SATURDAY, WHEN KEN FISHER SPOKE, AND TALKED ABOUT THE FACT THAT, IN HER READING OF THE ENTIRE ADULT SECTION OF THE PLAN, THE WORD FAMILY WASN'T MENTIONED ONCE.

AND I HOPE THAT, FOR MANY REASONS, ONE BECAUSE I THINK THAT IF THAT'S TRULY THE CASE, THE STATE HAS THE POTENTIAL TO JUST BOUNCE THAT PORTION OF THE PLAN DIRECTLY BACK TO US, SINCE CONSUMER AND FAMILY INVOLVEMENT IS SUPPOSED TO BE SO INTEGRAL IN ALL PARTS OF THIS.

I WOULD REALLY STRESS THAT -- I DON'T THINK IT WAS A CONSCIOUS CHOICE.

YOU BY IT IS PROBABLY IN SOME WAY AN OVERSIGHT, I HOPE, THAT FAMILY IS NOT MENTIONED THAT SECTION.

AND I WOULD STRONGLY SUGGEST THAT THE DEPARTMENT INCORPORATE THAT CHANGE INTO THE REVISED PLAN BEFORE IT GOES TO THE STATE.

THANK YOU.

>> Chair Turner: THANK YOU, MICHAEL.

JAMES SHAE KEYS.

>> THANK YOU, MADAM CHAIR.

I WOULD LIKE TO ECHO

MR. MEDEMA'S STATEMENT REGARDING CLIENT ADVOCACY, REGARDING A 24 HOUR DROP-IN CENTER, REGARDING VOCATIONAL SERVICES FOR CLIENTS, CONSUMERS EVER MENTAL HEALTH.

I BELIEVE -- I'M NOT SURE WHAT ANYONE ELSE HERE HAS HEARD THROUGHOUT THESE HEARINGS, OR HAS GONE THROUGH THROUGHOUT

THEIR LIVES, BUT I'VE ALWAYS  
HEARD PEOPLE SAYING WE WANT A  
PLACE WHERE WE CAN GO, WHERE WE  
CAN GET SOME HELP, WE WANT A  
JOB, WE WANT OUR OWN.

I BELIEVE THAT THE PLAN DOESN'T  
HAVE -- WELL, ADEQUATE LANGUAGE  
TO START A 24 HOUR DROP-IN  
CENTER.

I, MYSELF, FEEL THAT THIS IS  
VERY IMPORTANT, AND HAVING IT  
ALSO CLIENT-RUN.

OF COURSE WITH SUPERVISION OF  
CLINICAL PSYCHIATRISTS,  
REGISTERED NURSES, MAKING SURE  
THAT THEY'RE ADEQUATELY PAID,  
HAVING A PHONE LINE, AND ALSO  
HAVING OUTREACH IN THE FORM OF A  
CRISIS CENTER THAT GOES OUT TO  
THE CENTER TO THOSE IN THE  
STREETS WHO MAY NEED SOME HELP.  
THIS WILL DEFINITELY LESSEN  
5150'S FIGHT WITH THE POLICE,  
THIS WILL SAVE I DON'T KNOW HOW  
MUCH MONEY FOR OUR POLICE  
DEPARTMENT AND HOSPITALS.  
THAT MONEY IN ITSELF CAN BE  
TRANSFERRED BACK INTO MENTAL  
HEALTH.

I'M NOT SURE THAT THERE HAS BEEN  
ANY TYPE OF STUDIES DONE ON  
THAT.

BUT I WOULD HOPE THAT WE COULD  
LOOK VERY SERIOUSLY INTO  
INCREASING SOME OF THE MONEYS TO  
HAVING A 24 HOUR DROP-IN CENTER.  
THANK YOU.

>> Chair Turner: GIVEN HER  
TIME NEEDS, I'M GOING TO TURN  
THIS TO BARBARA, IF YOU WANT TO  
COMMENT.

>> I THINK THE COMMENTS ARE WELL  
MADE IN IT TERMS OF THE MANY  
ISSUES YOU ADDRESSED.  
ONE OF THE THINGS TO RECOGNIZE  
IS THIS IS OUR FIRST PLAN.

I DO WANT TO SAY THAT IT IS AN  
APPLICATION TO THE STATE, AND  
WHAT WE WANT TO DO, REALLY, WITH  
THE RICH INFORMATION THAT WE

HAVE, IS REALLY ROLL THAT INTO  
MORE OF A SERVICES PLAN AND A  
TRANSFORMATION PLAN.

AGAIN, I THINK PEOPLE CONSIDERED  
THAT THIS WOULD BE A 10 YEAR  
PLAN BUT IT'S REALLY AN  
APPLICATION EXPENDITURE PLAN TO  
THE STATE.

SO IT DIDN'T MEET THE NEEDS OF  
MANY I THINK FROM THEIR  
TESTIMONY.

SO WE WILL ATTEMPT TO DO THAT.  
I ALSO BELIEVE THAT THERE ARE  
SOME AREAS THAT WAS BROUGHT UP  
TODAY.

THE ISSUE OF FAMILY AND ADULTS  
WILL DEFINITELY BE WORKING -- I  
WANT TO ACKNOWLEDGE THE RESOURCE  
STAFF.

WE WILL BE MEETING WITH THEM, I  
ACTUALLY HAVE A TELEPHONE  
CONFERENCE WITH THEM TOMORROW  
AND THE LATTER PART OF NEXT  
WEEK, WE WILL WORK WITH THEM ON  
TRYING TO FINALIZE THIS.

OUR PROCESS WAS THAT THE TASK  
FORCE VOTED ON PRIORITIES, AND  
THAT'S HOW WE HONORED THE  
PROCESS IN TERMS OF THAT.

SO NOW WE HAVE AN IDEA, IT'S A  
WARM LINE, IT'S A CRISIS  
INTERVENTION.

BUT WE HAVEN'T HAD THE  
OPPORTUNITY TO WORK WHAT THAT  
PLAN'S DESIGN IS.

SO ONE IS THAT THESE ARE THE  
FIRST STEPS TOWARDS A LARGER  
DISCUSSION THAT WE WILL HAVE IN  
CALL TO THE COMMUNITY AT LARGE,  
FUR INTERESTED IN TALKING ABOUT  
THIS PARTICULAR PLAN OF THE  
CRISIS CENTER WARM LINE, WE'RE  
GOING TO HAVE AN OPEN PROCESS  
AND PEOPLE CAN COME IN AND WEIGH  
IN ON THEIR THOUGHTS.

FROM THAT, STAFF WILL DEVELOP  
ITS PROPOSALS.

THERE WERE MANY IDEAS.

WE HAD ALMOST 50 MILLION, 70  
MILLION WORTH OF IDEAS THAT ARE

REALLY IMPORTANT, EVERYTHING  
FROM A 24 HOUR MOBILE CRISIS  
CENTER TO A FULL 24 HOUR CENTER.  
AS YOU KNOW, 5 MILLION COULD NOT  
AFFORD TO PAY FOR ALL OF THOSE  
100%.

WHAT WE WANT TO DO IS TAKE THE  
FIRST STEP TOWARDS  
IMPLEMENTATION OF THAT, AND  
THAT'S WHAT WE WILL WORK ON.  
WE ARE IN THIS PROCESS FOR THE  
LONG PERIOD OF TIME.  
SO WE WERE GOING TO CONTINUE TO  
DO THIS.

WE HAVE OUR BUDGET PROCESSES  
FROM THE DEPARTMENT COMING UP.  
WE WANT TO DISCUSS ALSO HOW THAT  
MIGHT INTERACT WITH THE PROP 63  
DOLLARS.

SO WE'RE GOING TO KEEP THESE ON  
THE RADAR SCREEN AND THEY WILL  
BE THE PRIORITIES FOR THE  
COMMUNITY BEHAVIOR HEALTH  
SERVICES FOR THE NEXT DECADE.  
AND THIS PROCESS I THINK GAVE US  
ENOUGH RICHNESS OF INFORMATION  
THAT WE DO WANT YOU NOT TO BE  
CONFUSED BETWEEN THE EXPENDITURE  
PLAN THROUGH THE STATE AND A  
PLAN WE HAVE TO DEVELOP THAT IS  
INFORMED BY THAT PROCESS.

>> Chair Turner: WE HAVE A  
COUPLE MORE BOARD MEMBERS.  
GOING TO MOVE TO KATE WALKER.  
>> Board Member Walker: THANK  
YOU.

I WOULD LIKE TO MAKE AN  
OBSERVATION FIRST.  
5 MILLION MAY NOT GO VERY FAR.  
AND WHATEVER PLAN WE COME UP  
WITH, THERE ARE GOING TO BE  
PEOPLE WHO ARE DISAPPOINTED.  
BUT I'D LIKE TO SAY THAT I THINK  
ONE OF THE GREAT VALUES OF THIS  
WHOLE PROCESS, THAT A WHOLE LOT  
OF PEOPLE ARE TALKING TOGETHER,  
WITH DIFFERENT IDEAS.  
AND THE OTHER PEOPLE ARE  
LISTENING.  
AND THAT'S WORTH -- GOING TO BE

WORTH MILLIONS OF DOLLARS IN EFFICIENCY, I HOPE.  
I'D LIKE TO MAKE A ECHO THAT, AS A CRAZY PERSON MYSELF, I BELIEVE THAT IT IS AMONG THE PROFESSIONALS AND ALL THE REST OF US, THE PEOPLE -- THAT PEOPLE REALLY DON'T KNOW WHAT CRAZINESS IS.

AND IN DEVISING A PLAN TO HELP CRAZINESS, I HOPE THAT PEOPLE, WHO HAVE BEEN CRAZY, ARE CRAZY, UNDERSTAND WHAT IT IS TO BE CRAZY, WHICH PROFESSIONALS WHO HAVE NEVER BEEN CRAZY, CAN ONLY -- CAN'T REALLY KNOW.  
I HOPE THAT IDEAS FROM PEOPLE WHO HAVE BEEN THERE, WON'T BE OVERLOOKED.

BECAUSE IN LITERATURE, THERE'S NOTHING ABOUT THIS.  
THERE'S NO -- IT HASN'T BEEN DEVELOPED.

WE WON'T BOTHER WITH IT.  
THANK YOU.

>> Chair Turner: THANK YOU.  
BENITO CASADOS.

>> WHEN IT CAME TO CULTURAL COMPETENCY, IT WASN'T SET ASIDE FOR THE LATINO COMMUNITY, FOR THE AFRICAN-AMERICAN COMMUNITY OR ANYONE ELSE.

ONE OF THE THINGS THIS GROUP NEEDS TO BE IS SEND BACK TO THEM, AND SAY, LOOK, YOU'VE GOT TO PUT MORE MONEY ASIDE FOR THE CULTURAL COMPETENCY.

CULTURAL COMPETENCY IS IMPORTANT.

WE WANT THE SYSTEM TO SURVIVE AND THE SYSTEM TO WORK.

WE, AS A GROUP, NEED TO REALIZE THAT THAT IS VERY, VERY IMPORTANT ISSUE.

>> Chair Turner: MS. MCGEE.

>> THERE ARE A COUPLE OF THINGS THAT COME TO MIND IN REFERENCE TO I HEARD PEOPLE'S -- THEIR CONCERNS ARE.

ONE IS THE OUTREACH TO THE



COMMUNITY, EDUCATION TO THE  
COMMUNITY, THE 24/7 PHONE LINE,  
BEING ABLE TO ACCESS WHEN  
THERE'S A CRISIS.

I THINK WE'RE AT A -- IN A ERA  
WHERE BUDGETS ARE VERY TIGHT.  
AND THE 5.3 MILLION THAT  
EVERYONE HAS ALLUDED TO  
OBVIOUSLY IS NOT GOING TO MEET  
ALL THE CONCERNS.  
THE ONLY THING -- ONE OF THE  
CONCERNS I WOULD HAVE, AND  
BARBARA YOU CAN PROBABLY ANSWER  
THIS, IS THE FACT I WOULD LIKE  
TO SEE SOME FLEXIBILITY IF  
POSSIBLE, AS MY COLLEAGUE JUST  
MENTIONED. .

YOU HAVE A CERTAIN AMOUNT OF  
MONEY FOR CERTAIN CATEGORIES  
THAT OBVIOUSLY ARE NOT GOING TO  
MEET THAT NEED.

BUT MY QUESTION IS, ARE THERE  
GOING TO BE SOME FLEXIBILITY AS  
WE GO THROUGH THE PLAN, IF MONEY  
CAN BE SHIFTED TO OTHER AREAS  
THAT NEED MORE FINANCIAL  
ASSISTANCE?

SECOND IS I'D ALSO LIKE TO SEE  
THIS BOARD, SINCE WE ARE THE  
MENTAL HEALTH BOARD, REALLY  
CRITIQUE THE BUDGET AND FUNDING,  
AND WHERE THE ALLOCATIONS FOR  
THE MONEY WILL GO, AND HAVE A  
MUCH MORE ACTIVE ROLE.

OR OF OUR RESPONSIBILITY.

>> MEMBERS OF THE BOARD ARE VERY  
INTERESTED IN BEING A PART OF  
THE RFP PROCESS.

>> IT'S A PART OF THE ONGOING  
PROCESS.

>> IT IS OUR RECOMMENDATION THAT  
WE ARE.

>> (LAUGHTER.)

>> Chair Turner: ADDITIONAL  
COMMENTS FROM BOARD MEMBERS.

TOYE MOSES.

YOUR MICROPHONE.

>> Board Member Moses: [NO  
AUDIO.] ONE OF THE COMMENTS THAT  
CAME OUT LAST TIME WITH MAYOR

WAS ONE FROM A STAFF THAT TALK ABOUT THE SAFEHOUSES IN BAYVIEW, SPECIALLY.

THAT'S AN IMPORTANT THING THAT WE SHOULD CONSIDER.

WE ALSO HEARD ABOUT THE CAREGIVERS WHO ARE GRANDPARENTS, WHO REALLY CONCERN ABOUT THE KIDS, THEIR GRANDDAUGHTERS, AND THEY ARE SPENDING MOST OF THEIR MONEY, MOST OF THEIR INCOME, TO TAKE CARE OF THESE GRANDKIDS. WE SHOULD REMEMBER THAT. IS VERY, VERY IMPORTANT.

ALSO, TODAY, WE HAVE A VERY, VERY -- LADY THAT REALLY HAVE A LOT OF RESPECT FOR WHO WORK IN TENDERLOIN.

UNFORTUNATELY SHE HAVE RETIRE, WHO SMALL PART ON SENIOR ISSUE.

SHE ALSO TALK ABOUT SAFEHOUSE FOR SENIORS, YOU KNOW, AND SENIOR RECOVERY CENTER.

ALL THESE ARE VERY, VERY IMPORTANT.

I KNOW WE'RE TAKING CARE OF KIDS.

WE SHOULD ALSO CONSIDER SENIOR PROGRAM TOO.

SO WE SHOULD NOT FORGET THAT.

AND I HOPE THE TRAIN HAS NOT LEFT THE STATION.

SO LET'S REMEMBER ALL THESE ISSUES THAT CAME UP.

>> Chair Turner: TOM PURVIS.

>> I JUST WANT TO REITERATE WHAT SEVERAL PEOPLE HAVE ALREADY SAID.

CERTAINLY PAM FISHER ON SATURDAY POINTED OUT THE FACT THAT THE FAMILY WAS NOT MENTIONED, WITH ENOUGH PROMINENCE IN THE PLAN IT CERTAINLY SHOULD BE.

AND GOING BEYOND JUST THAT, I THINK SINCE I'M REPRESENTING NAMI IN PART, NAMI ITSELF NEEDS TO DO A BETTER JOB IN OUTREACH IN PULLING IN THOUSANDS OF FAMILIES THAT SHOULD BE INVOLVED IN THE PROCESS.

AND WE DON'T HAVE THOUSANDS.  
WE'VE GOT DOZENS.  
AND WE NEED TO DO A MUCH BETTER  
JOB.  
WE COULD USE A LITTLE MONEY TO  
LOOK FOR OUTREACH.  
WE'RE GOING TO USE MONEY WE'VE  
RAISED OURSELVES.  
THE ONLY OTHER COMMENT I WOULD  
MAKE I'M ASSUMING THE PLAN IS A  
STATEMENT OF WHAT THE FULL NEEDS  
ARE IN SAN FRANCISCO, WAY BEYOND  
WHAT JUST THE 5.3 MILLION CAN  
TAKE CARE OF, AS A STATEMENT OF  
NEED.  
THEN WE NEED THINGS THAT HAVE  
BEEN -- THAT HAVE BEEN SAID SUCH  
AS THE 24 HOUR CRISIS LINE.  
CAROLYN SAID SHE COULD SPEND TWO  
OR THREE HOURS AT A HOUSE.  
I CAN CONFIRM THAT.  
SHE WAS AT MY HOUSE THIS WEEK  
WITH THE SAN FRANCISCO POLICE  
DEPARTMENT FOR THREE HOURS.  
SO THAT'S ALL I HAVE TO SAY.  
>> Chair Turner: ANOTHER  
QUESTION BEFORE YOU HAVE TO  
LEAVE, BARBARA, IS TO ASK YOU  
ABOUT THE DATA FOR JAIL PSYCH  
SERVICES.  
I HAVE HEARD A NUMBER OF TIMES  
ABOUT THOSE DATA BEING  
INCORRECT, AND I HAVE PAGE  
NUMBERS AND ALL THE SPECIFICS TO  
GIVE YOU IN WRITING.  
BUT JUST WONDER IF THAT WILL BE  
CORRECTED BEFORE THE PLAN GOES  
IN.  
>> [NO AUDIO.]  
>> Chair Turner: SO THERE WILL  
BE DISCUSSIONS ABOUT THAT.  
>> [NO AUDIO.]  
>> Chair Turner: OKAY.  
BARBARA, I'M SORRY, YOUR MIC IS  
NOT TURNED ON.  
>> TO REPEAT WHAT I SAID, WE ARE  
WORKING ON THAT ISSUE, BUT DATA  
CAN BE PACKAGED IN DIFFERENT  
WAYS.  
SO THAT WAS PART OF THE

DISAGREEMENT OF WE WERE LOOKING  
AT A SNAPSHOT OR LOOKING AT  
PREVALENT DATA.

DR. BENNETT I THINK CAN GIVE US  
SOME DISTINCTION IN THAT.

>> [NO AUDIO.]

>> Chair Turner: THIS IS PAT  
BENNETT, DR. PAT BENNETT, WHO IS  
A CONSULTANT WHO WORKED WITH THE  
CITY AND TASK FORCE IN  
DEVELOPING THE WRITTEN PLAN TO  
GO TO THE STATE.

>> I HAVE A QUESTION THAT I WANT  
TO ASK BARBARA, OR ASK BOB, AND  
THAT IS WHY ISN'T THERE ANYTHING  
IN THE PLAN ABOUT WHAT SERVICES  
WILL BE PROVIDED FOR JAIL -- FOR  
PEOPLE THAT ARE IN THE COUNTY  
JAIL.

I KNOW THAT THE THING READS THAT  
YOU CAN'T HELP SET STATE AND  
FEDERAL PRISONERS WITH THE  
MONEY, BUT YOU CAN HELP THE  
COUNTY JAILS.

AND IF YOU READ THE PIECE THAT  
DOES SAY THAT.

>> I THINK EVERYONE'S FORGETTING  
THAT MOST OF THE MONEY IS GOING  
TO FULL SERVICE PARTNERSHIPS,  
WOULD INCLUDE ALL THESE KINDS OF  
SERVICES, PEOPLE WHO WOULD END  
UP IN JAIL, WE WOULD HELP  
GETTING PEOPLE OUT OF JAIL.

WE'RE NOT ALLOWED TO FUND  
SERVICES IN THE JAIL THAT WOULD  
SUPPORT OFFICERS, THE POLICE, OR  
ANY INTERVENTION LIKE THAT, BUT  
WE CAN SUPPORT THE SOCIAL  
SERVICES AND MENTAL HEALTH  
SERVICES NEEDED AS A TRANSITION  
OUT.

SO THOSE WOULD BE INCLUDED IN  
THE FULL SERVICE PARTNERSHIP.  
WE DIDN'T SPELL OUT THE DETAILS  
IN THE FULL SERVICE PARTNERSHIP  
BECAUSE WE WANT TO USE THE MODEL  
THAT WE ALREADY HAD.

FURTHERMORE, THERE WERE SEVERAL  
THINGS THAT THE TASK FORCE HAD  
TO RANK AND SOME OF THE SERVICES

THE BEHAVIORAL HEALTH COURT WERE LISTED BUT DIDN'T RANK HIGH. BECAUSE OF THE LIMITED FUNDING WE COULD DO THE TOP TWO OR THREE THINGS IN EACH AGE COLUMN

>> Chair Turner: I WAS GOING TO CALL ON IDELL WILSON.  
>> I WANTED TO SAY LET'S REALLY RECOMMEND THAT THEY KNOW WHO VOTED MAINLY ON THIS VOTE, WHERE THE MAJORITY, LET'S REMIND THEM A RECOMMENDATION WHEN IT COMES BACK, TO REMIND THEM WHERE THE MAJORITY OF THIS VOTE CAME FROM, SAN FRANCISCO, AND THE MAJORITY OF THE VOTE CAME FROM CONSUMERS. I KNOW EVERYONE WANTS TO GET A LITTLE BITTY -- YOU KNOW, A LITTLE BIT HERE, A LITTLE BIT THERE.

BUT THIS IS MAINLY FOR MENTAL HEALTH CONSUMERS TO GET MENTAL HEALTH ON TRACK.

>> Chair Turner: JAMES, AND THEN MICHAEL, AND CLAUDIA.  
>> THANK YOU, MADAM CHAIR.  
I WAS LOOKING AT THE SNAPSHOT OF SERVICES, FULL SERVICE PARTNERSHIP, SYSTEM DEVELOPMENT, AND OF COURSE THE TOTAL.

I SAW AT THE BOTTOM ADMINISTRATIVE OVERHEAD WHICH IS 15% OF THE 5.3 MILLION. IT CAME OUT TO 795,000. AND THAT'S ONE -- PLEASE TELL ME EXACTLY WHAT ADMINISTRATIVE OVERHEAD MEANS.

>> THE ADMINISTRATIVE OVERHEAD IS OUTLINED IN THE APPENDIXES ABOUT THE BUDGETS AND SO ON. NO NEW SERVICES CAN EVER BE DONE WITHOUT ADDITIONAL STAFF TO MANAGE, SUPERVISOR, GET PEOPLE HIRED TO DO ONGOING EVALUATION, TO INCREASE OUR INFORMATION TECHNOLOGY STAFF TO SUPPORT THE WORK.

MOST OVERHEADS IN BUSINESSES ARE ROUGHLY 15%.

WE CAN VARY THAT A LITTLE IN THE

COUNTY BUT THAT SEEMS TO BE ABOUT THE AVERAGE.

SO 15% WOULD BE USED TO BOTH CREATE AND ADMINISTER ALL OF THE PROGRAMS, INCLUDING THE FULL SYSTEM PARTNERSHIP AND SYSTEM DEVELOPMENT ISSUES.

SO THERE'S AT LEAST EIGHT STAFF THAT WOULD BE INCLUDED IN THE ADMINISTRATION AND AGAIN IT'S OUTLINED IN THE APPENDIXES.

>> HAVE YOU LOOKED AT ANY OTHER COFFERS WITHIN SAN FRANCISCO'S DEPARTMENT, TO FIND OTHER WAYS TO PAY FOR THOSE ADMINISTRATIVE SERVICES?

>> YES.

AND THERE ARE NONE.

>> Chair Turner: MICHAEL.

>> Secretary Medema: THANK YOU.

DR. SABI AND DR. GARCA -- I LIKE CALLING YOU DOCTOR TODAY. I HAVE A QUESTION ABOUT THE NEXT STEPS, ACTUALLY A COUPLE OF QUESTIONS.

THE FIRST BEING WHO IS DECIDING WHAT SUBSTANTIVE COMMENT MEANS, AND WHO'S -- AND WHEN WILL THAT SUBSTANTIVE COMMENT BE -- MY UNDERSTANDING OF THE READING OF THE TEXT OF THE MENTAL HEALTH SERVICES ACT, THAT THE SUBSTANTIVE COMMENT IS EITHER TO BE INCORPORATED OR EXPLAINED WHY IT CAN'T BE INCORPORATED.

SO WHAT I'M LOOKING AT IN MY TIME FRAME IS TODAY IS OCTOBER 24th, AND WE'RE HOPING TO ASK SOMEBODY IN THE CONFERENCE THAT

DR. SABI AND I ATTENDED LAST WEEK, FEDEX OUR -- TO THE STATE. BETWEEN THEN NOW AND WHO WILL BE DECIDING ON EVERYTHING WE'VE HEARD IN THE TWO HEARINGS, EVERYTHING THAT HAS BEEN E-MAILED AND WRITTEN, WHAT IS SUBSTANTIVE, WHEN WILL IT BE INCORPORATED AND WHEN WILL THE REVISED PLAN BE POSTED TO THE

PUBLIC?

>> WE HOPE THAT WILL HAPPEN --  
NOW NOVEMBER 1st, WE MAY BE  
SUBMITTING A PLAN THE FIRST WEEK  
OF NOVEMBER.

TODAY, WE HEARD SEVERAL OF YOUR  
COMMENTS FROM THE COMMENTS OF  
THE AUDIENCE TODAY, CERTAINLY  
YOU HIGHLIGHT SOME AREAS THAT WE  
WILL LOOK AT.

SO WE WILL BE MAKING THOSE  
DECISIONS FROM THE STAFF,  
DR. SABI AND MYSELF AND OTHERS  
WHO HAVE BEEN WORKING ON THIS  
BEHIND THE SCENES IN TERMS OF  
THE PLANNING COMMITTEE I HAVE IN  
THE DEPARTMENT, AS WELL THE  
RECORD OF THIS ENTIRE HEARING  
WILL GO AS AN ATTACHMENT TO THE  
PLAN.

AND SO ALONG WITH THE 500 PAGES  
OF ATTACHMENTS OF ALL OF THE  
RECORDINGS OF ALL OF OUR  
MEETINGS, ET CETERA.

BUT WE WILL TRY -- AND YOU  
IDENTIFIED SEVERAL OF THOSE  
PRIORITIES TODAY.

I HEARD PATIENTS ADVOCACY  
ISSUES, THE NEEDS OF THE 24 HOUR  
CRISIS ISSUES.

MANY OF THE COMMENTS YOU MADE  
TODAY WE CONSIDER AS  
SUBSTANTIATING IN THE PLAN AND  
WE NEED TO PUT THAT INTO THE  
PLAN.

BUT IT'S A DEPARTMENT DECISION.  
IT'S A DEPARTMENT PLAN.

SO IT IS OUR RESPONSIBILITY.

>> Secretary Medema: BARBARA,  
WILL YOU ALSO SHOW COMMENTS THAT  
WERE SUBSTANTIVE BUT CANNOT BE  
INCORPORATED AND EXPLAIN WHY IT  
CAN'T BE INCORPORATED INTO THIS  
PARTICULAR PLAN?

>> WE HAVEN'T MADE THOSE  
DECISIONS YET.

WE'RE JUST FINISHING THE HEARING  
TODAY SO WE WILL NEED A COUPLE  
OF DAYS TO FIGURE THAT ONE OUT.

>> Secretary Medema: MY LAST

QUESTION WAS, WE HEARD A LOT, SATURDAY AND TODAY, ABOUT TRANSFORMING THE SYSTEM. AND ONE OF THE THINGS THAT WE CONTINUE TO TALK ABOUT DURING THESE HEARINGS AND THE FUTURE IS WE'RE GOING TO HAVE OUR PLAN THAT WE HAVE IN FRONT OF US, BUT WE ALSO HAVE THE REST OF THE PLANS THAT ALREADY OPERATE WITHIN THE DEPARTMENT. THINGS THAT CAME OUT OF THE TASK FORCE, THINGS THAT CAME OUT OF ALL THE HEARING, AND -- WILL THOSE ALSO BE INCORPORATED INTO AREAS THAT ARE NOT SPELLED OUT SPECIFICALLY IN THIS PLAN? I MEAN I KNOW THE ANSWER TO THIS QUESTION.

I'M JUST HOPING THAT, FOR THE BENEFIT OF EVERYONE ELSE WHO MIGHT BE ABLE TO STATE WHAT THE ANSWER IS, THAT, YOU KNOW -- GO AHEAD.

>> WELL, IT'S REALLY IMPORTANT. IT WAS A VERY RICH PROCESS. WE LEARNED A LOT.

AND WE WANT TO INCORPORATE THAT INTO THE TRANSFORMATION IN OUR MENTAL HEALTH SYSTEM.

WE DO THAT THROUGH OUR ANNUAL REVIEW OF THE PROGRAMS.

I KNOW DR. SABI HAS TALKED ABOUT INCORPORATING MANY OF THESE ISSUES WITHIN THE ANNUAL PLAN OF COMMUNITY BEHAVIOR HEALTH SERVICES.

AND MANY OF THE RECOMMENDATIONS, THIS IS GOING TO TAKE US SEVERAL YEARS TO GRAPPLE WITH THIS.

AND EVERY YEAR, WE WILL HAVE PROBABLY AN UPDATE TO THE STATE, ALONG, WITHIN THREE YEARS, WE WILL HAVE ANOTHER PROCESS TO SUBMIT THE NEXT THREE YEAR PLAN. SO WE BELIEVE THAT WE WILL INCORPORATE THIS INTO I THINK A MORE CONSUMER FRIENDLY PLAN, THAT HOPEFULLY YOU'LL SEE AS MUCH INFORMATION AS POSSIBLE



WITHIN THAT.

>> I WAS GOING TO ADD, AGAIN THE RFP PROCESS IS ANOTHER WINDOW WHERE WE WILL INCORPORATE THAT AROUND PROP 63 BUT NEW RFP'S AROUND REBID SERVICES FOR BEHAVIORAL HEALTH WILL INCORPORATE THE SAME THING AND THAT'S WHERE THE TRANSFORMATIONS WILL KEEP HAPPENING.

>> Chair Turner: CLAUDIA LEVISH.

>> THANK YOU.

I'M CLAUDIA LEVISH, CONSUMER REPRESENTATIVE.

BEING APPOINTED TO A CONSUMER SEAT, MY VOICE IS SOMEWHAT GUIDED BY MY OWN PERSONAL EXPERIENCE.

BUT IT ALSO MUST BE INFORMED COMPLETELY BY TESTIMONY THAT I HEAR FROM CONSUMERS.

SO I THANK ALL OF YOU FOR COMING OUT TONIGHT AND IDENTIFYING YOURSELVES AS A CONSUMER AND I ALSO WANT TO THANK EVERYONE ELSE.

YOU ARE ALL WORKING FOR VERY WORTHY CAUSES.

AND, YOU KNOW, IF IT WAS UP TO ME, I'D GIVE YOU AS MUCH MONEY AS I CAN.

SO I WANT TO FOLLOW UP TO JAMES'S QUESTIONS REGARDING THE OVERHEAD COST OF 15% FOR ADMINISTRATIVE.

WE HEARD FROM THE REPRESENTATIVE TONIGHT THAT THE COST SHOULD BE REDUCED TO 10%.

ALSO, A LOT OF COMPANIES I KNOW DON'T CONTRIBUTE TO CHARITIES WHOSE OVERHEAD COST IS MORE THAN 5%.

SO I'M WONDERING, EVEN IF WE CAN GET THAT COST REDUCED TO 10%, THAT -- NEARLY 80,000 WOULD BE ENOUGH FUNDS TO PUT AT LEAST ONE 24/7 MOBILE CRISIS UNIT ON THE STREET.

THAT -- WE HEAR TESTIMONY FROM A

WOMAN ON THE SATURDAY MEETING,  
SAYING A LOT OF PEOPLE IN  
BAYVIEW HUNTERS POINT CAN'T GET  
TO THEIR MENTAL HEALTH  
PROVIDERS.

SO WHY CAN'T WE REDUCE THAT 10%  
AND PROVIDE THAT ONE MOBILE  
CRISIS UNIT THAT WILL ALSO HELP  
SENIORS GET TO THEIR MENTAL  
HEALTH PROVIDERS.

AND AS A FOLLOW-UP TO THAT, I  
WANTED TO ASK, COULD THAT  
POSSIBLY BE TIED IN WITH THE  
PEER-RUN SERVICES.

A FEW PEOPLE THAT ARE  
ADMINISTRATIVE BE PEERS?  
INSTEAD OF STRICTLY  
ADMINISTRATIVE OVERHEAD,  
MANAGERIAL?

>> THANK YOU FOR MAKING THOSE  
SPECIFIC COMMENTS AND  
RECOMMENDATIONS IN YOUR CAREFUL  
READING.

I ALSO WANT TO ASK LaVAUGHN  
KELLUM-KING TO GO NEXT.  
LaVAUGHN IS THE VICE  
PRESIDENT, VICE CHAIR OF THE  
MENTAL HEALTH BOARD.

>> Vice Chair Kellum-King:  
THANK YOU, DR. TURNER.

I WOULD LIKE TO EXPRESS MY  
GRATITUDE TO THE TEAM OF 40  
INDIVIDUALS WHO MADE THEIR WAY  
AROUND THE COMMUNITY.

THAT HAS BEEN VERY UPLIFTING FOR  
MYSELF AND MY LOVED ONE WHO IS A  
CONSUMER.

AND I STRESSED ON SATURDAY HOW  
IMPORTANT I THINK IT IS FOR  
FAMILIES TO BE INVOLVED.  
AND ALSO TO SAY TO EACH OF US IN  
THIS ROOM THAT WE HAVE TO TRUST  
THE PROCESS, AND IN TRUSTING  
THAT PROCESS, WE HAVE TO BE  
PRESENT.

AND I WAS GOING TO ASK OUR  
ILLUSTRIOUS LEADERS WITH THE  
TASK FORCE CONTINUE TO BE  
INTACT, AND I FOUND OUT THAT IT  
WOULD.

WHAT I DON'T KNOW IS WHAT WOULD THEIR PRIMARY ROLE BE, AND HOW OFTEN THEY WOULD BE MEETING, BECAUSE I THINK THAT WILL BE CRUCIAL. THOSE ARE MY COMMENTS FOR TONIGHT.

AGAIN, THANK YOU, DR. TURNER, AND ALL OF THE PEOPLE WHO SERVED ON THAT TASK FORCE AND WILL CONTINUE TO SERVE ON THE TASK FORCE.

THANK YOU.

>> Chair Turner: BEFORE WE GO BACK TO ANY FINAL PUBLIC COMMENTS, AFTER OUR DELIBERATION, I WANTED TO KNOW IF ANY OTHER BOARD MEMBERS HAVE MORE RECOMMENDATIONS, BASED ON YOUR READING OR YOUR UNDERSTANDING OF PUBLIC COMMENT. LISA WILLIAMS.

>> I WANTED TO ECHO WHAT MY COLLEAGUES SAID.

I HAVE A GREAT CONCERN ABOUT THE MOBILE CRISIS NOT EXISTING. AND IF THAT'S NOT GOING TO HAPPEN, THAT WE CAN LOOK INTO AREAS LIKE EDUCATION, AND WORK OUT SOMETHING THROUGH THE SCHOOL SYSTEM TO REACH FOLKS WHO CAN'T NORMALLY BE REACHED BY PARTICIPATING AND COMING OUT TO COMMUNITY MEETINGS.

THE OTHER GROUP I THINK WAS LEFT OUT, OR WE CAN FURTHER SOME DISCUSSIONS WITH OR INPUT IS THE FAITH BASED COMMUNITY IS ANOTHER AREA OF FOLKS AND COMMUNITIES, THE PLACES THEY GO, THERE ARE USUALLY NO SERVICES AVAILABLE TO THEM.

MY COMMENTS.

>> Chair Turner: THANK YOU.

I THINK THAT SOME OF THE LANGUAGE THAT COULD PERTAIN TO MOBILE CRISIS IS -- REMAINS VAGUE, AND THAT IT'S AT THAT POINT OF THE RFP PROCESS WHERE WE HAVE TO GIVE OUR INPUT.

THAT'S WHERE THINGS GET REALLY  
MATERIALIZED.

BENITO.

>> Board Member Casados: I  
WOULD LIKE TO MAKE A REQUEST TO  
THE EXECUTIVE COMMITTEE AND THAT  
IS ONCE THIS FINAL PROCESS GOES  
THROUGH, THAT EITHER DR. SABI,  
PREFERABLY BARBARA WOULD BE  
ASKED BACK, TO GIVE AN  
ACCOUNTING OF WHAT CHANGES WERE  
MADE, WHAT SOME OF THE REASONS  
THAT WERE GIVEN AS TO WHY OTHER  
CHANGES WEREN'T BEING GIVEN,  
RATHER THAN US BEING LEFT ON THE  
OUTSIDE TO FIND OUT FOR  
OURSELVES.

>> Chair Turner: ANY  
ADDITIONAL COMMENTS FROM MEMBERS  
OF OUR BOARD?  
JAMES.

>> THANK YOU, MADAM CHAIR.  
I WOULD LIKE IF YOU COULD JUST  
REITERATE, FOR THE BOARD, WHAT  
OUR RECOMMENDATIONS WILL DO,  
WHAT IT MEANS, AND WHETHER OR  
NOT MENTAL HEALTH HAS TO BE --  
REJECT, OR BRING IT BACK TO US.  
>> OUR RECOMMENDATIONS GO TO THE  
DEPARTMENT.

THERE'S ACTUALLY A TREMENDOUS  
AMOUNT OF INFORMATION FROM THE  
HEARING AT BAYVIEW, AS WELL AS  
THE COMMENTS THAT WERE MADE  
TODAY, AS WELL AS OUR OWN.  
THEY ARE ALL RECORDED.

AND THEY ARE IN THE HANDS OF THE  
DEPARTMENT.

NOTES HAVE BEEN TAKEN.

IF THERE'S ADDITIONAL THINGS  
THAT YOU WANT TO WRITE DOWN, ALL  
OF THESE GO TO THE DEPARTMENT.  
AND WHAT THEY HAVE TO DO IS TO  
RESPOND TO RECOMMENDATIONS THAT  
HAVE BEEN MADE, IN WRITING, WHEN  
THEY PASS THEIR REPORT TO THE  
STATE.

THEIR APPLICATION FOR FUNDING.  
AT THIS POINT, OUR ROLE AS A  
MENTAL HEALTH BOARD, IS ENDING

WITH THIS HEARING, IN TERMS OF  
THE APPLICATION TO THE STATE.  
WE GIVE OUR FEEDBACK, AND WE ARE  
FACILITATOR FOR PUBLIC COMMENT  
TO THE DEPARTMENT.

IN OTHER WORDS, WE DO REMAIN  
INVOLVED IN THE PROCESS.  
IT'S NOT THE END.

IT'S JUST THE END OF THE HEARING  
PROCESS AND THE RECOMMENDATION  
PROCESS.

>> THANK YOU, MADAM CHAIR.

I BELIEVE THAT I NOW UNDERSTAND  
EVEN MORE.

THANK YOU.

>> Chair Turner: ANY OTHER  
COMMENTS?

JAMES MCGEE.

>> JUST ONE.

WILL WE BE GIVEN LIKE AN  
EXECUTIVE SUMMARY, LIKE WE WERE  
REFERENCED TO A BREAKDOWN OF OUR  
COMMENTS BEFORE IT GOES TO THE  
STATE?

OR CAN WE REQUEST THAT EXECUTIVE  
SUMMARY?

BECAUSE THAT WAS VERY HELPFUL ON  
THE PREVIOUS DRAFT THAT IT WAS  
BROKEN DOWN, THE KEY POINTS.

I'M WONDERING CAN WE GET THAT  
SAME PROCESS BEFORE IT'S  
SUBMITTED TO THE STATE SO THE  
BOARD HAS OPPORTUNITY TO REVIEW  
THAT?

>> Chair Turner: WE CERTAINLY  
WILL GET EVERYTHING TO GOES TO  
THE STATE.

WHETHER OR NOT IT CAN BE BROKEN  
DOWN IN TERMS OF A BRIEFER  
EXECUTIVE SUMMARY IS SOMETHING  
WE CAN REQUEST.

I DOUBT IT GIVEN THE TIME FRAME.  
THE SOONER THEY FILE THE  
APPLICATION, THE SOONER THE  
FUNDING WILL BE AVAILABLE.

I'M NOT CERTAIN WE CAN GET A  
EXECUTIVE SUMMARY BUT WE HAVE  
ACCESS TO MEMBERS OF THE  
DEPARTMENT.

>> WELL, THAT'S GREAT.

BASED ON WHAT WAS TOLD, THAT  
ONCE THE APPLICATION IS  
SUBMITTED, THEN IT'S LIKE THREE  
MONTHS AFTER THAT BEFORE THEY  
RECEIVE THE FIRST PHASE OF THE  
MONEY.

SO THERE'S A PROCESS THAT'S  
GOING TO BE DONE.  
IT'S NOT LIKE THEY'RE GOING TO  
RECEIVE THE MONEY INITIALLY.  
SO WHETHER IT GOES IN ON  
NOVEMBER 1st OR NOVEMBER 5th  
FOR EXAMPLE, IT'S STILL A LEE  
MONTH PROCESS THAT'S GOING TO  
TAKE PLACE.  
AND IT'S GOOD FOR THE BOARD TO  
AT LEAST LOOK AT THAT BEFORE  
THAT IS SENT IN.

>> Chair Turner: YOU'RE RIGHT.  
THE EARLIEST IT COULD BE SEEN IS  
FEBRUARY.  
>> RIGHT.

IT'S URGENT BUT THERE IS TIME  
FOR THIS BOARD TO BE ABLE TO  
LOOK AT THAT AND HAVE IT BROKEN  
DOWN FOR US.

>> Chair Turner: MICHAEL.  
>> Secretary Medema: IN SOME  
RESPONSE TO YOUR COMMENTS,  
JAMES, THERE'S BEEN MULTIPLE  
READINGS OF THE LAW IN THE WAY  
THAT THE LAW IS APPLIED -- OR  
THE ACT IS APPLIED.  
IN OTHER COUNTIES, THE PLAN HAS  
HAD THE COMMENTS ATTACHED TO  
THEM, AND THEN THE REVISED PLAN,  
WITH COMMENTS, HAS BEEN SENT  
BACK TO THE LOCAL MENTAL HEALTH  
BOARD FOR ANOTHER REVIEW, TO  
INSURE THAT THE COMMENTS HAVE  
BEEN INCORPORATED.

I KNOW THAT OUR EXECUTIVE  
DIRECTOR, MS. BROOK, HAS BEEN  
CONSTANTLY, AT THE PRODDING OF  
MANY OF US ON THE PHONE, WITH  
CAROL HOOD FROM THE STATE  
DEPARTMENT OF MENTAL HEALTH,  
WHO'S TOLD US NOW THAT THE PLAN  
DOES NOT HAVE TO COME BACK TO  
THE MENTAL HEALTH BOARD FOR

ANOTHER REVIEW.

I PERSONALLY STAND IN DIRECT  
OPPOSITION TO THAT, AND THAT IS  
NOT HOW TO READ THE ACTED.

I THINK IT'S ABSOLUTELY INSANE  
THAT THERE'S NOBODY PUBLICLY  
REVEALING TO INSURE THAT  
SUBSTANTIVE COMMENT HAS BEEN  
INCORPORATED INTO THE PLAN.

SO, FRANKLY, I MEAN I DON'T --  
I'M NOT A CYNIC -- WELL, I AM,  
BUT NOT IN THAT DEGREE OF A  
CYNIC TO BELIEVE THAT THE  
DEPARTMENT'S GOING TO IGNORE  
MANY OF THE SUBSTANTIVE  
COMMENTS.

BUT I THINK THAT MY READING OF  
THE ACT IS THAT IT SHOULD COME  
BACK TO THE MENTAL HEALTH BOARD.  
I AGREE WITH YOU WHOLEHEARTEDLY  
THAT ANOTHER, YOU KNOW, THREE  
DAYS OR WHATEVER, TO FEDEX THE  
PLAN OUT TO US FOR ONE MORE  
REVIEW OR SOMETHING DOESN'T SEEM  
LIKE THAT BIG OF A DEAL.

>> Chair Turner: WHAT I WANT  
TO DO IS JUST ALLOW BOARD  
MEMBERS TO BRIEFLY FRAME VERY  
SPECIFIC RECOMMENDATIONS AT THIS  
POINT.

ANYTHING THAT YOU WANT TO  
SUMMARIZE, THAT YOU WANT TO  
FINALIZE, THAT YOU WANT TO MAKE  
SURE GOES AS A SPECIFIC  
RECOMMENDATION.

SO IT'S NOT QUESTIONS,  
SUGGESTIONS, OR OTHER THOUGHTS,  
BUT VERY, VERY SPECIFIC  
RECOMMENDATIONS THAT YOU WANT TO  
FRAME.

AND I'LL GIVE EVERYBODY A MINUTE  
TO PULL THEIR THOUGHTS TOGETHER  
ABOUT THAT.

I'M GOING TO START WITH TWO  
SPECIFICS THAT CAME FROM OUR  
SATURDAY MEETING.

AND TONIGHT WERE REITERATED.  
ONE OF THEM IS THAT FAMILY  
TREATMENT BE SPELLED OUT  
SPECIFICALLY IN THE PLAN.

IT WAS DISCUSSED IN THE EXECUTIVE SUMMARY, BUT NOT AS SPECIFIC IN THE PLAN. AND TO MAKE IT CLEAR THAT THERE'S A FAMILY ORIENTATION, THAT FAMILY MEMBERS OF CONSUMERS ARE INVOLVED TO THE EXTENT POSSIBLE IN TREATMENT. SECONDLY, THAT OUTCOMES BE SPECIFIED AS CLEARLY AS CAN BE, BECAUSE THAT IS WHAT ACCOUNTABILITY IS. AND WE HAVE ASKED FOR AN OUTLINE OF OUTCOMES AND HOW THEY WILL BE MEASURED. SO I MOVE TO -- ARE YOU NEXT, MICHAEL? OR, JAMES, DO YOU HAVE ANYTHING YOU WANT TO SPECIFICALLY FRAME AN SUMMARIZE?

>> Secretary Medema: WELL, THE ONLY THING THAT I WOULD PROBABLY FRAME AND SUMMARIZE WOULD BE THE OUTCOME OF THE FAMILY AND YOUTH. I THINK IS A EXTREMELY IMPORTANT COMPONENT OF THE PLAN, AND ESPECIALLY AREAS OF ALSO OUR SENIORS, THAT OUR SENIORS NEED -- OUTREACH TO OUR SENIORS NEED TO BE MUCH BETTER ALSO. SO FAMILY, YOUTH, SENIORS.

>> Chair Turner: MICHAEL.

>> Secretary Medema: THE RECOMMENDATIONS I'VE MADE I THINK ARE PRETTY CLEAR. THE TWO THAT I WOULD MAKE ARE THE ONE, THAT THE EXECUTIVE SUMMARY WOULD BE INCORPORATED AND THE SUBSTANTIVE COMMENTS BE SENT TO THE BOARD REVIEW.

>> Chair Turner: JAMES.

>> THANK YOU, MADAM CHAIR. I BELIEVE THAT MORE SERVICES SHOULD BE GIVEN TO OUTREACH, AND PERHAPS THE SHIFTING OF SOME OF THE FULL SERVICE PARTNERSHIP MONEYS, THAT CAN ACHIEVE THAT SPECIFIC GOAL, AND OF COURSE I WOULD LOVE TO SEE A MOBILE TEAM UTILIZED WITH THAT MONEY ALSO.



THANK YOU.

>> Chair Turner: ANY FURTHER COMMENTS TO FINALIZE FROM EITHER TOM OR LISA?

>> I BELIEVE THE WHOLE ISSUE OF FAMILY INVOLVEMENT HAS BEEN SPELLED OUT ADEQUATELY.

I GUESS THE ONLY OTHER THING I WOULD MAYBE WANT TO MAKE, IF IT'S NOT ALREADY THERE, THAT ALL THE NEEDS BE INCLUDED IN THE PLAN, EVEN THOSE THAT CAN'T BE FUNDED, AND THAT OTHER PROGRAMS BE GIVEN A HIGH PRIORITY, SUCH AS A 24 HOUR MOBILE CRISIS CENTER, EVEN IF THAT CAN'T BE FUNDED IMMEDIATELY, THAT IT BE GIVEN A HIGH PRIORITY, ALONG WITH OTHER PROGRAMS THAT WE IDENTIFY -- ON THOSE THAT CAN BE ALLOCATED IN THE -- [NO AUDIO.]

>> I WILL REMEMBER THAT THERE'S MORE SERVICES FUNDING TO GO TO SCHOOLS, THE WELLNESS CENTERS.

>> Chair Turner: ANY OTHER COMMENTS ON THIS SIDE OF THE ROOM?

FINAL COMMENTS?  
RECOMMENDATIONS.

>> YEAH.

I WOULD LIKE TO ONCE MORE SAY I WOULD LIKE TO SEE CULTURAL COMPETENCY DEFINED.

I WOULD LIKE TO SEE MORE VOCATIONAL OUTREACH, SUCH AS INTERNSHIPS AND STUFF DONE.

>> Chair Turner: KATE.

>> Board Member Walker:

CURRENTLY, CONSUMERS ARE SAYING NOTHING ABOUT US WITHOUT US.

I BELIEVE, MICHAEL, THAT YOU ASKED BARBARA GARCA SOMETHING ABOUT JUST WHO IS DEVELOPING THE PLAN, WHO IS WRITING IT.

I WONDER IF -- WHO IS WRITING THE PLAN?

WHO IS DECIDING WHAT WILL BE IN THE PLAN?

I WISH I WERE ABLE TO KNOW A BIT MORE ABOUT HOW THE PLAN IS BEING

PRODUCED AT THE HIGHEST LEVEL.

>> Chair Turner: THANK YOU.

>> AGAIN, I WOULD LIKE TO RECOMMEND THAT SERIOUS CONSIDERATION BE GIVEN TO ALL THE CAREGIVERS, ESPECIALLY THE GRANDPARENTS WHO CARE.

>> Chair Turner: CLAUDIA.

>> THANK YOU.

OTHER THAN WHAT I SAID ABOUT THE 24 HOUR MOBILE CRISIS OUTREACH PROGRAM, I THINK IT'S VERY DIFFICULT FOR US TO DEAL WITH A SMALL -- A SMALLER THAN EXPECTED AMOUNT OF MONEY THAT WE RECEIVED.

SO WE HAVE TO USE THAT MONEY AS FIRST RESPONDER, NOT LIKE FEMA USED IT AND THE BEST WAY TO DO IT IS ON THE CONSUMER WHICH INCLUDES THE 24 HOUR CRISIS AND 24 HOUR DROP-IN CENTERS AND PREVENTATIVE MEASURES.

WE MUST REACH TRANSITIONAL YOUTH BEFORE THEIR ISSUES ARE UNATTENDED TO, AND THEY FALL INTO A LIFE OF VIOLENCE OR SUBSTANCE ABUSE.

SO THOSE WOULD BE MY TWO PRIMARY RECOMMENDATIONS.

>> Chair Turner: OKAY.

SUMMARIZING THINGS I'VE HEARD MULTIPLE TIMES, ABOUT 24 HOUR MOBILE CRISIS, CULTURALLY COMPETENT CARE, ALSO GENDER-SPECIFIC CARE, WITH RESPECT TO EMPIRICALLY VALIDATED TREATMENTS, CERTAINLY THERE IS A LOT OF RESEARCH-BASED KNOWLEDGE ABOUT GENDER-SPECIFIC CARE, AND FINALLY SCHOOL-BASED SERVICES. THAT'S ALSO SOMETHING THAT THE BOARD HAS BEEN INVOLVED IN, AND SEEN AS A PRIORITY FOR QUITE A LONG TIME.

OKAY.

I AM GOING TO -- BEFORE WE TAKE A VOTE, THE BOARD WILL TAKE A VOTE THAT THE COMMENTS THAT WE HAVE FRAMED, EACH OF US

INDIVIDUALLY, AS MARKED FROM THE POINT WE STARTED UNTIL NOW, THAT WE PUT THOSE FORWARD TO THE DEPARTMENT IN WRITING, THAT THOSE ARE COMING FROM THE SAN FRANCISCO MENTAL HEALTH BOARD, IN RESPONSE TO THE DRAFT PLAN.

BEFORE WE MOVE TO THAT VOTE, I'M GOING TO ASK FOR A PUBLIC COMMENT ON THE BOARD'S DISCUSSION, WHICH WAS AFTER THE LAST PUBLIC COMMENT. IS THERE ANY MEMBER WHO WISHES -- PLEASE COME UP AND STATE YOUR NAME. THANK YOU.

>> GOOD EVENING. MY NAME IS -- HERE IN SAN FRANCISCO. I NOW WORK EXCLUSIVELY IN PRIVATE PRACTICE. AND NO LONGER SOMEWHAT SADLY, LONGER WORK IN ANY SORT OF COMMUNITY MENTAL HEALTH PROGRAM OR GOVERNMENT FUNDED PROGRAM. AND THAT HAS LARGELY BEEN BECAUSE -- I GUESS WHAT I'M TRYING TO SAY IS THAT I HEARD A LOT OF THE CONSUMER VOICES SAYING VERY CLEARLY THAT THEY WANTED TO REALLY MANAGE DOWN THE MONEYS SPENT TOWARD ADMINISTRATIVE COSTS, AND TO REALLY MAKE SURE THAT THERE WAS MONEY FOR CLINICAL SERVICES AND DIRECT SERVICES TO THE CONSUMERS.

AND I JUST WANTED TO SAY THAT I PRESENT IN THE DISCUSSION BUT I DIDN'T HEAR THAT GO INTO THE RECOMMENDATIONS.

AND I'D LIKE TO SAY THAT FROM THE PROVIDER SIDE, I ALSO THINK THAT THAT'S IMPORTANT BECAUSE I THINK THAT, IN MANY WAYS, MENTAL HEALTH PROFESSIONALS CAN MOSTLY SELF-SUPERVISE, AND THAT THE ADMINISTRATIVE FUNCTIONS, AND SOMETIMES POLITICS GET IN THE

WAY OF THE SERVICES THAT CAN BE PROVIDED.

SO I'D LIKE TO SUGGEST THAT.

THANK YOU.

>> Chair Turner: THANK YOU.

ARE THERE OTHER MEMBERS OF THE PUBLIC, INDICATE BY RAISING YOUR HAND, IF YOU'D LIKE TO MAKE A COMMENT, BASED ON THE BOARD'S RECOMMENDATIONS.

SEEING NONE, PUBLIC COMMENT IS CLOSED.

THE MENTAL HEALTH BOARD HEREBY FORWARDS THE FOLLOWING RECOMMENDATIONS, I SHOULD SAY THE PREVIOUS RECOMMENDATIONS THAT WE HAVE JUST STATED IN OUR TAPE RECORDING.

TO THE DEPARTMENT OF PUBLIC HEALTH FROM OUR INDIVIDUAL BOARD MEMBERS, AND THESE ARE REGARDING THE DRAFT PLAN FOR THE MENTAL HEALTH SERVICES ACT.

ALL THOSE WHO AGREE, SAY AYE.

>> AYES.

>> Chair Turner: ALL OPPOSED, NO.

>> NAY.

>> [NO AUDIO.]

>> MADAM CHAIR, CAN WE HAVE A POINT OF CLARIFICATION.

ARE WE MOVING FORWARD THE RECOMMENDATIONS THAT HAVE BEEN HEARD OVER TWO DAYS WORTH OF -- TWO HEARINGS WORTH OF TESTIMONY, OR ARE WE MOVING FORWARD THE RECOMMENDATIONS THAT WE JUST SUCCINCTLY STATED AT THE END, OR THAT WE'VE STATED AT OTHER POINTS DURING THE HEARING AS WELL?

BECAUSE THERE'S BEEN A LOT OF RECOMMENDATIONS FROM BOARD MEMBERS ON SATURDAY AS WELL, THAT WEREN'T NECESSARILY PART OF TODAY'S.

SO I'M JUST CURIOUS WHAT WE'RE MOVING FORWARD.

>> Chair Turner: AS I JUST STATED WHAT WE'RE MOVING FORWARD

ARE THE COMMENTS WE JUST FRAMED,  
WHICH WE TAPED FROM THE POINT  
THAT I STATED GOING FORWARD.  
SO EACH BOARD MEMBER FRAMED  
THEIR SPECIFIC RECOMMENDATIONS.  
THOSE ARE, FOR CLARIFICATION,  
THAT IS WHAT WE'RE MOVING  
FORWARD TO THE DEPARTMENT, AS  
OUR INDIVIDUAL BOARD MEMBERS  
RECOMMENDATIONS.

>> COULD I JUST CLARIFY THAT THE  
RECOMMENDATION TO REDUCE THE  
ADMINISTRATIVE COST WAS INCLUDED  
IN THAT?

>> Secretary Medema: THAT'S  
WHY I SAID MAY.

>> Chair Turner: I'M NOT  
CERTAIN IF YOU STATED THAT WHEN  
YOU FRAMED YOUR FINAL COMMENT.  
SO I CAN'T SAY.

>> THAT'S THE FINAL COMMENT, BUT  
THE INITIAL COMMENT.  
IF NOT, I WOULD LIKE TO MAKE  
THAT AS A RECOMMENDATION.

>> Chair Turner: THAT WAS NOT  
INCLUDED.

THEN YOU NEED TO RESTATE THAT.

>> I WOULD LIKE TO RESTATE THAT,  
THAT I WOULD LIKE TO SEE THE  
ADMINISTRATIVE COST CUT IN ORDER  
TO PROVIDE A 24/7 CRISIS MOBILE  
UNIT.

>> Chair Turner: SO THAT IS AN  
ADDENDUM TO EACH OF THE  
INDIVIDUAL COMMENTS THAT WE  
SUMMARIZED AT THE END, THAT WE  
TAPED GOING FORWARD.  
CAN THOSE BE TRANSDERIBED FOR  
US, RICH?

CAN THOSE FINAL COMMENTS BE  
TRANSDERIBED?

OKAY.

BUT THESE FINAL COMMENTS  
SPECIFICALLY THAT ARE MOVING  
FORWARD AS THE BOARD'S  
RECOMMENDATIONS.

I WOULD LIKE TO ASK YOU TO CALL  
THE ROLL.

>> JAMES MCGEE, AN AYE FOR THE  
RESOLUTION.

>> MICHAEL MEDEMA, NAY.  
>> JAMES KEYS, AYE.  
>> TOM PURVIS, AYE.  
>> LISA WILLIAMS, AYE.  
>> DR. TOYE MOSES, AYE.  
>> CLAUDIA LEVISH, AYE.  
>> BENITO CASADOS, NAY.  
>> KATE WALKER.  
>> REBECCA TURNER, AYE.  
>> LaVAUGHN KELLUM-KING, AYE

>> WE HAVE NINE AYES AND TWO  
NAYS.  
OUR RESOLUTION PASSES.

Item 3.0 PUBLIC COMMENT

>> Chair Turner: ANY MORE  
PUBLIC COMMENT ABOUT ANY ITEMS?  
OKAY. SEEING NONE THE MEETING IS ADJOURNED.

THE MEETING WAS ADJOURNED AT 7:00 P.M.





## SAN FRANCISCO MENTAL HEALTH BOARD

Gavin Newsom  
Mayor

1380 Howard Street, Suite 510  
San Francisco, CA 94103  
(415) 255-3474 fax: 255-3760  
mhb@igc.org  
www.sfgov.org/mental\_health

### MEETING OF THE MENTAL HEALTH BOARD

Wednesday, November 9, 2005

101 Grove Street  
3rd Floor, Room 300  
6:30 p.m.

**PLEASE NOTE: THIS MEETING IS BEING HELD AT**  
**101 Grove Street, Room 300**

### AGENDA

DOCUMENTS DEPT.

NOV - 8 2005

#### CALL TO ORDER

#### ROLL CALL

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#### AGENDA CHANGES

#### Item 1.0 DIRECTORS REPORT

For discussion.

##### 1.1 Dr. Robert Cabaj, Director, Community Behavioral Health Services

A report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

##### 1.2 Public comment relevant to Item 1.0

#### Item 2.0 PRESENTATION - THE IMPACT OF VIOLENCE ON MENTAL HEALTH

##### 2.1 LaDonnis Elston, Ph.D., Assistant Director, Adult Services, Lynn Westry, Family Involvement Team and by video, Yul Dorn, Family Mosaic Project.

##### 2.2 Discussion of possible future actions related to presentations

##### 2.3 Public comment relevant to Item 2.0

#### Item 3.0 ACTION ITEMS

For discussion and possible action.

##### 3.1 Public comment relevant to Item 3.0

##### 3.2 Consent Calendar:



3.2.a PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of October 12, 2005, be approved as submitted.

3.2.b PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of October 22, 2005, be approved as submitted. (Minutes from this public hearing can be found on our website, at the Main Branch of the Public Library, and at the Board of Supervisor's office.)

3.2.c PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of October 24, 2005, be approved as submitted. (Minutes from this public hearing can be found on our website, at the Main Branch of the Public Library, and at the Board of Supervisor's office.)

#### **Item 4.0 REPORTS**

For discussion and possible action..

- 4.1 Report from the Executive Director of the Mental Health Board
- 4.2 Report of the Chair of the Board and the Executive Committee.
- 4.3 Report by members of the Board on their activities on behalf of the Board.
- 4.4 New business - Suggestions for future agenda items to be referred to the Executive Committee.
- 4.5 Public comment relevant to Item 4.0

#### **Item 5.0 PUBLIC COMMENT**

Members of the public may address the Mental Health Board on any items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board.

#### **ADJOURNMENT**

##### **DISABILITY ACCESS**

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD). Five days notice before the meeting will help to ensure the presence of an ASL interpreter or sound enhancement system. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.
2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and 14 Mission. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley which runs on the opposite side of the building from 10th Street.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

### **POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES**

The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

### **KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE**

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Frank Darby  
Sunshine Ordinance Task Force  
City Hall, Room 244  
1 Dr. Carlton B. Goodlett Place  
San Francisco, CA 94102-4689  
Telephone: (415)554-7724  
Fax: 4(15) 554-5163  
E-mail: [sotf@sfgov.org](mailto:sotf@sfgov.org)

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from Ms. Hall, or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: [www.sfgov.org/sunshine.htm](http://www.sfgov.org/sunshine.htm)

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: [www.sfgov.org/mental\\_health](http://www.sfgov.org/mental_health). You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

### **Lobbyist Registration and Reporting Requirements**

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site [www.sfgov.org/ethics](http://www.sfgov.org/ethics).



# SAN FRANCISCO MENTAL HEALTH BOARD



1380 Howard Street, Suite 510  
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[www.sfgov.org/mental\\_health](http://www.sfgov.org/mental_health)

## UNADOPTED MINUTES Mental Health Board Wednesday, November 9, 2005 Health Commission Chambers 101 Grove Street, 3rd Floor San Francisco, CA 94102 6:30 p.m.

DOCUMENTS DEPT.

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**BOARD MEMBERS PRESENT:** Rebecca Turner, Ph.D. (Chair); John Kevin Hines; Claudia Lebish; James L. McGhee; Toye Moses, Ph.D., M.P.H.; Tom Purvis; Dorothy Shaffer, R.N., N.P., M.S.N.; Kate Walker; Lisa Williams; Idell Wilson.

**BOARD MEMBERS ABSENT:** Benito Casados; Bob Douglas, J.D.; Supervisor Bevan Dufty; James Shaye Keys; La Vaughn Kellum-King; Michael Medema; Jagruti Shukla, M.D., M.P.H.

### PRESENTERS:

LaDonnis Elston, Ph.D., Assistant Director, Adult Services, Community Behavioral Health Services  
Lynn Westry, Family Involvement Team, Community Behavioral Health Services  
Yul Dorn, Family Mosaic Project (by video)

**OTHERS PRESENT:** Robert Cabaj (Director of Community Behavioral Health Services); Tina Hasselman (Janssen Pharmaceutica); Teresa Moore (SFUSD Head Start); Giuliana Halasz (HSMC, PACEAPP); Michael Lukso; Colleen Matthews (SFGH, 6B); Emeric Kalman; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

### CALL TO ORDER

The meeting was called to order at 6:35 p.m. by Rebecca Turner, Chair.

### ROLL CALL

### AGENDA CHANGES

No changes.

## 1.0 DIRECTORS REPORT

### 1.1. Report from the Director of Community Behavioral Health Services

Dr. Cabaj: We received sad news last week that Jeff Jue, former Director of Community Mental Health Services, passed away due to complications from valley fever, a rare illness.

SSI is a benefit that helps stabilize people. But it was reduced by the federal government. We still actively enlist clients into SSI. I think the evidence from the Urban Health Study will help us show the federal government that SSI helps people stay stable.

The Mental Health Board has requested that I talk about our programs with regard to violence and trauma. As we all know violence and trauma is one of the biggest problems faced in our community. The number of deaths from shootings has gone down a bit in the past year, but it is still very high and they are concentrated in certain communities.

We've had a special program at the Center for Special Problems for domestic violence, both for perpetrators and victims. We've had a CIRT team (Critical Incident Response Team), that works with community-based organizations. The Trauma Recovery Center at SFGH is at risk of losing funding. The State has interpreted the way it is being funded differently, saying it should be individually-based vs. program-based.

Our Mobile Crisis Team is consistently responding to situations of violence and our Child Crisis Team responds to situations of violence. They help with interventions, and also help with early intervention and prevention around post traumatic stress syndrome as a result of trauma or violence.

For over a year and a half, we've had a Committee looking at gun violence. As a result, there have been programs under Barbara Garcia, Deputy Director of Health. We have someone who responds to every shooting in the city. The police have asked us to do that. Previously, the response was only in the case of shooting deaths. But now the team responds to all shootings and the response team meets with the victim's family members, and with witnesses.

We're trying to reorganize that service, because it is a lot of pressure on a small group of people, and we're looking for more funding for that. Under our Prop 63 plan, we will be having more funding for violence response services. We would hope to have many more services.

In addition, the SFGH has also been the home for CASARC (Child Adolescent Sexual Abuse Resource Center) which is a program which responds to children who have been victims of sexual trauma in the community. This is a state-supported program. It's located at the hospital because the children sometimes need medical services.

Community Focus and Citywide Case Management have client members who were formerly in jail, some of whom were perpetrators. And we have a very active Jail

Psychiatric Services, which includes people who have been victims of violence and people who have been perpetrators.

Mr. Purvis: Has the state supported the harm reduction efforts or do they oppose them? I'm surprised naloxone is not more used.

Dr. Cabaj: Our city is very supportive, the Bay Area is supportive. Sacramento is somewhat supportive, but the Federal government is totally against it and does not even allow the use of the words "harm reduction."

The Directors written report was distributed:

**Jeff Jue.** We received the sad news last week that Jeff Jue, LCSW, former Director of San Francisco Community Mental Health Services, passed away due to complications from a respiratory illness. Jeff was a social worker/administrator for 32 years. Prior to retiring in 2002, Jeff last served as Director of the Community Services Agency for Stanislaus County. Before that, he served as director of mental health and drug and alcohol programs in California for over 25 years, with stints as mental health director for Merced, Sonoma, and San Francisco counties. He is past president of the California Mental Health Directors Association, and has been actively involved in legislative and policy advocacy as a member of the National Association of Social Workers Board of Directors and the California Welfare Directors Association. He received his B.A. in Social Welfare at San Francisco State University (1968), and MSW at the University of California, Berkeley (1970). Jeff was 62, and a native of San Francisco. He will be sorely missed.

**City's Fatal Overdoses Drop with Harm Reduction.** The number of fatal overdoses in San Francisco have dropped ever since harm reduction programs were implemented in the county. Drug overdose may soon surpass auto accidents as the leading cause of accidental deaths in California, but in San Francisco, the death from drug overdoses is at its lowest level in nearly a decade. The number of overdose deaths in San Francisco, which has one of the highest rates of drug use in the state, has fallen from 178 in 1998 to 144 two years ago. (Since then, the number may have dropped even further to fewer than 100 deaths annually.) Meantime, the statewide figures went up 42% for the same time period.

San Francisco has embraced a number of harm reduction practices in recent years. For example, in 2003, San Francisco became the first county in the state to publicly fund naloxone distribution. Naloxone is a medication that can revive an overdosing opiate addict within minutes. Addicts in San Francisco have reported saving 116 fellow-addicts with the medication.

**SSI Helps.** Preliminary data from an Urban Health Study (University of California-San Francisco) suggested that intravenous drug users (IDUs) who received SSI benefits were more stably housed, less reliant on illegal income, used drugs less frequently, and shared needles less often than IDUs without SSI benefits. In other words, it appears that SSI benefits contribute to general life stability and a reduction in drug-related harm. This finding is consistent with many other studies that have shown that drug users who

receive income supports and/or subsidized drug treatment are less likely to be homeless, engage in illegal activities, or use drugs.

**EMS High-Users Project Saves Lives.** The Homeless Outreach and Medical Emergency (HOME) Team, which is a joint project between Emergency Medical Services and San Francisco Department of Public Health, was recently featured in the San Francisco Chronicle (October 5, 2005 issue). The HOME Team outreaches intensively to chronic homeless inebriates who are high-users of county emergency services, to help them get onto mental health/substance abuse treatment and to a safe and stable home. To learn more about this commendable project, please read the SF Chronicle article at:  
<http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2005/10/05/MNGB5F2OBR1.DTL&hw=inebriate&sn=003&sc=287>

#### Other Upcoming Events:

**BIDDERS' CONFERENCE: SUBSTANCE ABUSE OUTPATIENT SERVICES -** On Tuesday, November 15, at 3:30 - 5:00 PM, at CBHS, 1380 Howard St., 4th floor conference room, a pre-proposal conference will be held to answer questions from potential applicants/bidders to the CBHS Request for Proposals for Substance Abuse Outpatient Treatment Services. The goal of this RFP is to redefine and restructure the substance abuse component of Behavioral Health Services. An estimated total of \$10,000,000 is available for contract awards for these services based on current year funding. To receive a copy of this RFP, please contact:  
Office of Contract Management and Compliance, 1380 Howard Street, 4th Floor - Room 442, San Francisco, CA 94103-2614, Phone: (415) 255-3518, (415) 255-3490, (415) 255-3502 or E-mail: [sheila.maxwell@sfgov.org](mailto:sheila.maxwell@sfgov.org)  
Or visit: <http://www.dph.sf.ca.us/contracts/RFP252005/RFP252005pg1.htm> to download the RFP package.

#### 1.2 Public Comment relevant to Item 1.0

Member of the public: I have a question about the development of the program at Jail Psychiatric Services.

Dr. Turner: We actually don't answer questions during the public comment time of this meeting, but talk to us afterward and we'll tell you how to get your question answered.

#### Item 2.0 PRESENTATION

Rev. Dorn (by video): My name is Yul Dorn, and I work for the Family Mosaic Project. I'm also pastor of the True Light Church in the Bernal Heights area. I also serve as a responder to the shootings we see in our community.

I wanted to talk to you today, because this is of enormous importance to me. The violence that's going on in our community has direct correlation to mental health. I'm glad you are taking time to consider this.



The violence has really reached epidemic proportions. Young people are dying at an alarming rate. Many of the families I pastor have been impacted by gun violence. I have been impacted myself with the loss of my nephew. Just some of the circumstances surrounding the violence let you know that there must be some mental health issue related to this.

In order to kill someone, to take someone's life, you have to have something inside you that's not balanced that allows you to take someone's life.

I really feel like it's a serious problem that we don't have enough people who are really showing they care for what's going on. The young people are feeling that it's hopeless over here in Hunters Point/Bayview, which is where I live and work, and which is where I grew up. It's almost like the whole community is under siege. If something is not done, we're going to have major, major problems.

I want to give you a scenario. I actually arrived on the scene shortly after an episode of violence. There were young people all over the street and they were hyperventilating and they were willing to talk to anyone. They were reaching out. Some were saying, "I've never seen anything like this before in my life. I was just with him and now he's dead."

After time, as these incidents keep happening and happening, the feelings scab over. By the time of the funeral they have their game faces on again. But right there in that tender moment, just after the shooting, that's when you can help these young people.

Even myself, in my own family, there is hardly a night when we don't hear gunshots in the Hunters Point community. Even though someone has not been hit, hearing the gunshots triggers post traumatic stress.

This is a community under siege; people don't want to come out at night.

People are self-medicating, using meth, trying to deal with what they are seeing on a day-to-day basis. Many of them have close friends and relatives who have been victimized. We have schools that have no idea of what's going on in the community, no idea of what the kids have encountered just to get to the school and then they are expected to be able to learn.

You're not safe on the school bus. You're not safe on the campus. They have found weapons on campuses. You have people walking around with PTSD.

We need to get the word out.

I ask you who are sitting on the Mental Health Board to do what you can to get funding for programs to help people in response to trauma and violence both for Bayview/Hunters Point and also for the Western Addition. This needs to be done and done now. The heroin rate they say is lower, but living in this community, I know that that doesn't mean anything to people suffering from post traumatic stress.



We need clinics that are open past 5 o'clock. People with mental health issues often don't get up till noon. Unfortunately mental health episodes don't have a time clock. People might need meds at 8 p.m. at night. We need to reach out to people where they are.

I'm willing to do all I can. Maybe we will get some of our churches involved. But we have to do something. Otherwise we're just watching this epidemic get larger.

I'm willing to do anything I can. Thank you very much for your time.

Ms. Westry: I am a survivor. My oldest daughter was killed in September 1998. Prior to that my best friend was killed. Prior to that I was raped, and both my legs were broken. I had to learn to walk again. And my house was shot into.

I've lived a very traumatic life. I don't know why. It's not due to my upbringing. I had a very Christian upbringing. My father was in the home. So I don't know why I've been through so much. Maybe it's so I could be here today.

There's a lot of PTSD going on. I'm one of many who have been suffering in our community, and who have not gotten the kind of treatment they needed.

I went to SFGH once or twice, but people were not trying to get inside of what I needed, what does Lynn need? And the people there were not people who look like me or understood our community. Treatment needs to be more culturally competent. It's not necessarily that everyone has to have the same background as you. But the clinicians have to be culturally competent.

I was working in mental health, but was not able to get the services I needed. So I knew I had to fight for my people. No one was going out to the families, no one was bringing services to families. When we go out to the scene, we go as a team. We've been through violence ourselves. It's re-traumatizing for us to go out to scenes of violence, but we want to help people.

We don't have the backup we need. This hasn't been made a priority. We've heard a lot of talk. But if you're really concerned about people, you'd be out there helping them. The majority of the kids in our program have been impacted by violence.

We're just putting a bandage over the problem and these kids need serious help. And the families are being re-traumatized over and over again. Every night you're hearing gunshots, you're hearing cars go up and down. You don't feel safe. Our system has not treated this as a priority. Plans have been put on paper. They look good, they sound good, but we are not really reaching people with help.

This time of the year is hard for me. It starts getting hard in September which is when my daughter was killed. I get sick, my stomach hurts, I get depressed. If it weren't for colleagues and friends I would be giving up. The City has not been good at responding to the needs of the community.

I think we can do a lot better, and we're going to have a lot more mental health issues if we don't start helping people.

Dr. Elston: Thank you, Lynn. As you can see, Lynn is one of the parents who is really suffering from the violence.

Up to this time there have been 74 killings. At least 60 of those are of African Americans. The killings are primarily in the Bayview and Western Addition, but mostly in Bayview. One reason I was glad to hear Dr. Cabaj talk about services, is like Lynn, I want to raise the need to look at the lack of services.

Dr. Cabaj talked about the CIRT team. CIRT is now just one person, so it's no longer a team. Myself, Lynn, Yul and a few others have put together a preventative team. In the past, everything we've seen has not worked well.

Some of the things Yul mentioned, are things we really need, like drop-in clinics and culturally-competent services. If you can't relate to a person, it's hard for you to help that person get through the situation they are in. People make comments like, "Those people don't want to work. They're lazy." But when Wal-Mart had 200 jobs open, 1200 people lined up at 5 a.m. to get those jobs.

If we could get a few jobs, a few trainings in the neighborhood, so there could be some other hope besides having to sell drugs and rob people, that would make a difference. One of the things we've seen in the Bayview, is there have been grants of \$500,000 up to \$1 million to serve people. There are organizations which are very good at getting grants. They assess the community and get the grants, but by the time they get staff set up and have all the programs in place the grant is over. And very few people have received services, but the money is spent.

A lot of people who live in the Bayview would have a hard time getting a grant. So it's people from the outside who win the grants. What we're hoping is that with Proposition 63, we can have something more stable. We want sustainable programs, not programs which are here today and gone tomorrow, so people in the community can have some hope.

We need a safe house in the community. We would love to have two. If there was a refuge that people could go to, that would help. It's worked in other areas.

We also need a drop-in clinic with evening hours, so we can catch people at the time when they are ready to talk to someone. A lot of the grandmothers or families with kids can drag them on the bus to a treatment center, but if a clinician came by the home that would really help them.

If you could help to spread the word about what the Bayview community needs that would be very appreciated.

Dr. Turner: Who is funding these grants where people came in from the outside?

Dr. Elston: The state and federal government provide the grants. Both have been very interested in violence. And there are some private grants, too.

Dr. Turner: Someone is signing off on these grants, allowing them to come into the community.

Dr. Elston: Our committee was talking today about the need for an oversight committee to review these grants.

Dr. Turner: There's the problem of the negative cycle, that if the programs don't show good results then it's harder to get funding in the future.

Dr. Elston: Often the people running these programs blame people in the community instead of doing outreach to make the programs work.

Ms. Westry: The program looks good on paper, but they are not coming out and asking the people who are supposedly getting the service. I think they need to go to the people and ask the people what they need. I think that's the one missing thing in Bayview/Hunters Point is the accountability. That makes people feel like the people running the programs don't care about this community. They just throw anything our way and don't ask what we want and what we need. Again there's a lot of money in the Bayview Hunters Point, but I don't think program funding is being allocated properly.

Mr. McGhee: When you say "they," that doesn't help me. Who do you mean when you say "they" come into the community?

Dr. Elston: They are programs and providers in San Francisco. I have seen people get grants, but the objectives of the program have not been met.

I have talked with many people in the Bayview who live there, who talk about going to a training, like Yul took training to be a carpenter, but there was no job at the end of the training. But the people who came in and ran the trainings had done their training and left. Yul still has his carpenter's belt hanging there brand new, because he has never had a chance to use his belt.

Mr. McGhee: Are any of these organizations still in operation in the Bayview?

Dr. Elston: There are a few that are still operating. They will do whatever they get money for.

Mr. McGhee: The reason I ask about this, is when you talk about accountability, if these organizations are still in operation that are doing this, then I think the Board would like to know so we can assist with accountability.

Dr. Elston: We appreciate this. But we need to take action to stop this. And we need to make sure that people are culturally competent.

A family called that number that Dr. Cabaj gave you on the flyer, but nobody responded at that number. And that's one of our own agencies. And we need to ask them to be more responsible.

Ms. Westry: I was at the scene of a homicide, a mother who had been killed. A family member brought the 13-year old daughter to the scene. And the daughter was so upset she wanted to commit suicide to go be with her mother.

We tried calling the number of our own system. My supervisor got through. But the first response of the staff we got through to was that he didn't know where the Alemany projects were. He started explaining where Child Crisis was and telling us to bring the child there. I told him I work right down the hall from Child Crisis and knew where it was, but how can I bring a child to Child Crisis who is talking so seriously about suicide?

That's an example of the barriers we're up against. I was begging the family members not to take the daughter from the scene, because I thought help was on the way, but it turns out that was not true, and this staff person didn't even know where the Alemany projects were at.

We need a sense of hope. We need to know that people are out there who care about us. Our babies are dying. How can we not treat this as a priority? If this Board can help us with this, and help with taking a stand, we'd really appreciate it. We have this big system. There should be people ready to respond to our community.

Dr. Moses: I want to thank you, Dr. Elston. I want to thank you too, Lynn, for sharing your experience with us. This Board is here to advocate for consumers and providers. I'm amazed to hear these things. I would call such providers community rapists, if they are getting the money but not providing the services.

This Board will go after them. I hope the train has not left the station. I hope they are still around. I think we should do something about it. I'm sure we have some very good staff who can help us identify these people.

Dr. Elston: In the past everyone was trusting that providers would do the right thing. We need to make sure that people are now accountable.

Ms. Westry: I think it's evident that whatever they should be providing they are not. Because then we would not be having this discussion today. There would be money allocated for more teams to respond and do the follow up work. We do need to look at this as a priority. This is not just a mental health issue, but also a physical health issue.

Dr. Moses: I want to make a quick comment. I remember many years ago when Supervisor Sophie Maxwell just got elected, she had a meeting even before she took office, and we talked about the crisis in the Bayview. I'm not sure whether anything came out of it. I think we, the Mental Health Board, should recommend to Sophie Maxwell that she could call a hearing on this issue. We as the Board can't do much, but we can encourage her to have a hearing.

Ms. Westry: At first Sophie was not responding as we hoped, but now she is. I call her personally at home when there is a shooting. She gets up out of her bed at two in the morning and comes out. She's realizing how much of this is a mental health issue. And she has been an advocate for Prop 63 money to go to violence issues.

Dr. Elston: She did hold a hearing last Monday on gun violence.

Dr. Moses: Don't get me wrong, we need to ask her to hold a hearing on these providers who go around collecting money and not providing services.

## **2.2 Possible future action**

Dr. Turner: I think what Toye is saying is crucial, and it's alarming. I'm wondering if there is a community coalition of providers that may have influence and oversight over providers that come into the community.

Ms. Westry: There is the Bayview Be Magic program through the Public Defenders Office. It's made up of many organizations focusing on the violence in the Bayview.

Dr. Turner: I think it's a good recommendation that someone signs off on them if they are set up to provide services in the community. They need to be held accountable.

Ms. Shaffer: I think we should get information on what's working and not working.

Dr. Moses: I think we should start with Sophie Maxwell. This Board can't do much, but we can recommend to Sophie Maxwell's office to sponsor a hearing so we can look into these organizations.

Dr. Turner: In your presentation, you did a really good job of telling us what you think would make a difference: access, cultural competency, vocational and training programs, getting actual jobs, and drop-in centers with evening hours.

Mr. Hines: How about getting in touch with San Francisco Suicide Prevention? They have a homicide prevention team as well. Like with the young women who was suicidal, they can help.

Mr. Purvis: Is there any part of the Prop 63 package that's allocated to programs in that area?

Dr. Turner: It is set as one of the top priorities for Prop 63 funds. There are not a lot of specifics at the moment, but it is a top priority.

Ms. Brooke: As Dr. Turner said it's a priority. What we have coming is the design of the proposals and then the response to proposals. We need to make sure people from the Bayview get on the panels that design the Requests for Proposals (RFPs) and select the winning proposals that will be funded.

Dr. Moses: The presentation from the Family Mosaic Project was interesting. I'm wondering if we could follow up with FMP? I've been told the leader of FMP has resigned. We need to address this, and help plan for the hiring of the new director.

## **2.3 Public Comment**

Colleen Matthews: I'm a psychiatric social worker at San Francisco General Hospital, but more importantly I'm a survivor. My son was killed in 1996 by a hit and run driver who was drunk and using drugs.

I consider alcohol and drugs as violence. I went to a funeral recently and I was deeply, deeply touched. Here I was almost ten years after my son's death, and the violence is escalating and things have not gotten better. I've been working in community organizations for a long time. There are a lot of good people in many organizations, but the technical assistance is not there. The paraprofessionals are just not sufficient. They are trying to work with very meager means to help to heal a very, very huge problem.

I was really surprised to see the gentleman who did the presentation by video. He said everything I've said to myself in the last two months. I'm willing to do whatever it takes. Mental illness does not have a time schedule. It can happen in the middle of the night. And we need cultural competence. It's become a household word, but we need to know how to live it and breathe it.

I'll leave my card and we can talk more in depth about this issue.

## **Item 3.0 ACTION ITEMS**

### **3.1 Public comment relevant to Item 3.0**

No public comment.

### **3.2 Consent Calendar**

**3.2.a RESOLUTION (MHB-2005-32):** Be it resolved that the minutes of the Mental Health Board meeting of October 12, 2005, be approved as submitted.

**3.2.b RESOLUTION (MHB-2005-33):** Be it resolved that the minutes of the Mental Health Board meeting of October 22, 2005, be approved as submitted. (Minutes from this public hearing can be found on our website, at the Main Branch of the Public Library, and at the Board of Supervisor's office.)

**3.2.c RESOLUTION (MHB-2005-34):** Be it resolved that the minutes of the Mental Health Board meeting of October 24, 2005, be approved as submitted. (Minutes from this public hearing can be found on our website, at the Main Branch of the Public Library, and at the Board of Supervisor's office.)

(Passed with a yes vote from all present except Kate Walker.)

## **4.0 MENTAL HEALTH BOARD COMMITTEES**

### **4.1 Report from the Executive Director of the Mental Health Board**

Ms. Brooke: The Board did a fabulous job with the Prop 63 hearings. Many people have said complimentary things.



#### 4.2 Report of the Chair of the Board and the Executive Committee

Dr. Turner: Many of us are relieved to have the hearings done, and have been to many meetings. Although we will continue to follow up with Prop 63, it will be a new focus for a while. In the past year, a lot of things have changed. We have a number of new board members. Our Board has been very active in the community, and have worked in association with other agencies. I hope I will see everyone at the Retreat on December 3rd. It will be a time to redefine ourselves in terms of who we are now, and what our focus will be for the next year.

In February, it's time to re-elect officers for the Board. The Executive Committee has selected four people to serve as the Nominating Committee. They are Toye Moses, James McGhee, LaVaughn Kellum-King, and Jagruti Shukla. They will announce their selection of a slate of candidates at our January meeting and then our vote will take place at our February meeting. At that time members can also nominate candidates from the floor.

Dr. Moses: In terms of the MHB budget how are we doing?

Ms. Brooke: We're doing fine, we're right on target.

Dr. Moses: What about the Prop 63 plan?

Ms. Brooke: The plan is supposed to be submitted at the end of this week. We don't get the plan back. We will get it when it is submitted to the State. Then we can see if they have included our suggestions.

Dr. Moses: Don't we get it back before it goes to the State?

Ms. Brooke: The way the legislation was written it looked like it was supposed to come back to us before being sent to the State. But Carol Hood at the State Department of Mental Health, said no, it would be submitted directly to the State.

Mr. Hines: Are we going to get directly involved with the suicide barrier? They have raised \$1.8 million of the \$2 million for the study of the barrier.

Dr. Turner: We can take that up at the Executive Committee.

Mr. Hines: Thank you.

Dr. Turner: Are there any activities Board members want to report on?

Dr. Moses: I want to thank Kevin who was in the *San Francisco Chronicle* on November 2nd. Do you want to share something about that?

Mr. Hines: The *Chronicle* ran a seven part series on suicide from last Sunday to this past Saturday. It opened a lot of eyes. We changed a lot of minds about putting the barrier up on the Golden Gate Bridge. The Psychiatric Society of Northern California is leading the campaign to put up a barrier. There is the argument that people who are suicidal will go somewhere else. But suicide on the Golden Gate Bridge is an impulsive act, and if you can divert people you can save lives.

#### **4.4 New business**

Dr. Turner: Kevin you've just referred one item to the Executive Committee.

Mr. Hines: I'll be bringing some information to the Board and ideas for five simple things each of us can do to help the campaign on our own outside the Board.

Dr. Moses: What's going on with Family Mosaic? There is a new Director for YGC. who we could invite. We could invite the President of the Board of Supervisors to come and be our guest.

Dr. Turner: He said he would come.

Ms. Wilson: I'd like us to get the Mayor to come to one of our meetings to see us and get to know us, and see that we are out here doing this work.

Mr. Hines: I'd like to invite Youth Funding Youth. They are an amazing group of youth who run the entire program themselves and give out grants.

#### **4.5 Public comment relevant to Item 4.0**

Michael Lukso: One thing that is a special concern is Jail Psychiatric Services (JPS). I'm currently in the Behavioral Health Court. I made a suicide attempt. I spent a month and a week in JPS. I saw some things going on in jail that could use some change. I would like JPS to have some watchdog voice over what happens between deputies and inmates. I saw deputies taking a rough hand towards JPS clients. They switch your meds, so you don't know what you're taking anymore. They changed my medications and gave me Elavil, and the problem is that's what I overdosed on. If this falls into your realm, I'd like to see some attention to that area.

#### **Item 5.0 PUBLIC COMMENT**

There was no public comment.

#### **ADJOURNMENT**

There being no further business, the meeting was adjourned at 8:02 p.m.





SAN FRANCISCO MENTAL HEALTH BOARD



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**THE MENTAL HEALTH BOARD MEETING  
FOR WEDNESDAY, DECEMBER 14, 2005  
IS CANCELED.**

**Instead the Board will be holding its Annual Retreat  
from 9 a.m. to 4 p.m.  
on Saturday, December 3, 2005**

No final votes will be taken on any action items at the Retreat. All issues arising at the Retreat which require a vote of the Board will be placed on the agenda for the regular meeting of the Board on January 11, 2006. For further information, please call the office at 255-3474.

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# SAN FRANCISCO MENTAL HEALTH BOARD



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## MENTAL HEALTH BOARD Retreat Notes

Saturday, December 3, 2005  
Hotel Nikko  
222 Mason Street  
San Francisco  
9 a.m. - 4 p.m.

**BOARD MEMBERS PRESENT:** Rebecca Turner, Ph.D. (Chair); Benito Casados; John Kevin Hines; James Shaye Keys; LaVaughn Kellum-King; Claudia Lebish; James L. McGhee; Toye Moses, Ph.D., M.P.H.; Tom Purvis; Dorothy Shaffer, R.N., N.P., M.S.N.; Jagruti Shukla, M.D., M.P.H.; Kate Walker; Lisa Williams; Idell Wilson.

**BOARD MEMBERS ABSENT:** Bob Douglas, J.D.; Supervisor Bevan Dufty; Michael Medema.

**OTHERS PRESENT:** Robert Cabaj (Director of Community Behavioral Health Services); Helynna Brooke (MHB Executive Director); Rich Snowden (MHB Administrator).

## MEETING NOTES

### CALL TO ORDER

The Retreat was called to order at 9:03 a.m. by Becky Turner, Chair

### ROLL CALL

### AGENDA CHANGES

No changes were made.

### WELCOME AND INTRODUCTIONS

### ICEBREAKER

## ITEM 1.0 WHO ARE WE: Our Mission, Our Values, Our Goals

For discussion.

### 1.1 PowerPoint presentation by Becky Turner with discussion by the full Board.

#### BOARD MEMBERS AS LEADERS AND MENTORS

Good morning and here's the day

- Overview of the year 2005

- Who we are: Revisiting our mission and goals

- The big picture

- Small groups of 5 and then come back together into a big group.

After lunch

- Action goals for 2006

- How to implement action goals

- Program reviews, Board meetings, committees, networking, political action, education, individual actions, etc.

Implementation: It's all about Board members as leaders and mentors

Identity

- Who are we???

- What do mental health boards look like?

- Ask Google...images

Who are we?

- We're like a new board in many ways

- Many new board members

- And there has been a "cultural change"

Who was here last year?

- Bob, Bevan, LaVaughn, Toye, Dorothy, Becky, Idell, Michael, Helynna, Rich, Kate, Joel, Carol, Bridgett

Who is new this year?

- James M., James K. Benito, Jagruti, Lisa, Tom, Claudia, Kevin

- Roughly there is a 50% change.

What about it?

- Prop 63 helped

- More people know who we are

- Increased standing in community

- Closer relationship with CBHS, DPH, MHA

Priorities from last year's Retreat

- Proposition 63, the Mental Health Services Act

- Participate in City's Proposition 63 Steering Committee and planning process.
- Help ensure clients and family members have a strong voice in the planning process.
- Hold public hearing on the draft plan
- Address other key mental health issues in the Prop 63 context.
- Help serve as the conscience of Prop 63 to keep implementation true to intent.

On the times they are a changin'

- Formalized our meetings by getting a consultation on Sunshine Laws
- No longer take questions from the public during meetings.
- Have more expertise in public hearings/testimony.
- Changed our by-laws to require that board members do not miss than 4 meetings in the last 12 months. If necessary a leave of absence may be obtained for two months.
- We held meetings in City Hall and at Health Commission.

#### 2005 Activities/Accomplishments

- Press conference/kick-off with MHA
- Involved with Prop 63 Task Force and sub-committees
- Prop 63 hearings.
- Board members went to Sacramento and Berkeley Prop 63 trainings.
- Met with the Mayor
- Board members met with all Supervisors or their aides.
- Involvement and support for our Supervisor member, Bevan Dufty.
- Important speakers at our meetings - Mitch Katz, Barbara Garcia, Bob Okin, Supervisor Bevan Dufty.
- Executive Committee
  - Becky (Chair), LaVaughn (VC), Michael (Sec'y), Idell (Consumer rep), Lisa
- Stakeholders Committee
  - co-chaired by Lisa and Jagruti
- Budget Committee
  - chaired by Michael

#### Revisiting our Mission

Current:

The Mental Health Board of San Francisco represents and ensures the inclusion of the diverse voices of consumers, family members, citizens, and stakeholders in advising how mental health services are administered and provided. Through its state and city mandates, the MHB reviews, advocates and educates; with the aim of having that advice integrated, incorporated, and reflected in implementation of mental health policy; with the ultimate goal of ensuring quality mental health services.

Questions about the mission and goals (keep this "high")

- Does the current mission statement reflect our values and purpose?
- Do we wish to change any part of it?
- How do we wish to be known by SF?
- What are the overarching goals suggested by the Mission?

What do these imply that we need to do or to do differently?

For example, areas to think about...

- Board meetings/speakers/format
- Political action
- Committees
  - how many, structure
- Individual Board member activities
  - types
- Program reviews
  - format

## **1.2 Public comment relevant to Item 1.0**

There was no public comment.

## **ITEM 2.0 ACTION GOALS FOR 2006**

### **2.1 Discussion of priorities for 2006 and specific action goals related to the priorities.**

The implementation goals from agenda Item 3.0 are listed under the relevant action goals here under Item 2.0.

Dr. Turner's brief PowerPoint presentation:

Why? Because we have to "operationalize" them

Brainstorming our goals one per page

- What does it mean?

- How will we accomplish it?

- Who will do it?

- When will we do it?

- How will we know when we've accomplished it?

Board members as leaders and mentors

- How have you been a leader in the past 5 years?

- How would you like to be a leader in the next year?

Brainstorming session:

### **POSSIBLE COMMITTEES FOR THE MHB**

- Executive Committee

- Budget/Legislative Committee

- Public Relations Committee

## THREE MAJOR GOALS

### **1. Develop new partnerships with other mental health organizations in order to collaborate on mental health issues.**

PFNC, Psychiatric Foundation of Northern California  
San Francisco Suicide Prevention  
NAMI, National Alliance for the Mentally Ill, San Francisco  
Mental Health Association, San Francisco  
SPUR, San Francisco Planning and Urban Research Association  
CalNet, California Network of Mental Health Clients  
Forensic Mental Health Association.  
Policy Council for Women's Mental Health  
SFUSD School Board  
SFUSD, San Francisco Unified School District  
Youth Funding Youth Ideas  
Coleman Advocates  
Chamber of Commerce  
Support for Families of Children with Disabilities

Key questions: What is the purpose of outreaching to these organizations? What are our shared goals? What is the overlap and what do we want to accomplish by contacting them?

Draft letters and make phone calls to the people you know. Invite them to a meeting of some kind.

Increase contact to stakeholders regarding future Prop 63 activity.

Invite leaders of these other groups to attend our Board meeting when we have a speaker who is interesting to them.

NAMI has a twelve week, free course for family members or loved ones. LaVaughn has taught this course.

NAMI has a 24-hour line that people can call.

Annual meetings with every mental health organization we can find. Mental Health Senate.

### **2. Lead and participate in education and advocacy efforts in identified legislative areas.**

Golden Gate Bridge Barrier, keep updated, be at crucial GGB board meetings.

Follow up on Prop 63, education and prevention is coming next.

Every Board member can increase your connection with your appointing supervisor.

Board should meet and finalize what we're going to say to Supervisors, when we meet with them, so we don't have 11 people saying 11 different things to the Supervisors.

Invite Supervisors, one a month, to our Board or committee meetings.

We could get the Supervisors on the calendar for the year. We could let them speak first, and ask them what issues they're hearing from their constituents that they would like to have the Board look into. In that way, we'd show them that we're willing to do something for them.

Work on laws on women and mental health, review legislation around women, such as custody laws, and domestic violence



Adequate day care system for young children.

Change the name of the Mental Health Board to the Mental Health Commission. State law allows this so it would be a change to the City ordinance, and add our duties around Prop 63 to the City ordinance.

### **3. Provide education to San Francisco organizations and the community about critical mental health issues.**

Newsletter and website

Speakers bureau to speak about different subjects such as suicide prevention, mental disorders, domestic violence, educating people as to certain topics.

Family to Family teaching

Putting statements in voter pamphlets

Mental health issues in child care, options for mentally ill children.

Gang violence/PTSD

Grandparents who care, caregivers

Bring in more consumer presenters as well. Look at our meetings and how we spend that time so it's more goal driven, and coming in prepared and what we are going to discuss, and an idea of what we're going to do before the next meeting.

An additional item: Increase MHB budget so the Board can accomplish more.

#### **2.2 Public comment relevant to Item 2.0**

There was no public comment.

## **ITEM 3.0 HOW TO IMPLEMENT ACTION GOALS**

### **3.1 Making an implementation plan.**

See item 2.0 above for the implementation actions which are listed under the relevant Action Goals.

#### **3.2 Public comment relevant to Item 3.0**

There was no public comment.

## **ITEM 4.0 FINAL COMMENTS FOR THE DAY**

### **4.1 Comments from Board members**

Board members made individual comments about the day.

#### **4.2 Public comment relevant to Item 4.0**

There was no public comment.

## **ITEM 5.0 PUBLIC COMMENT**

There was no public comment.

## **ADJOURNMENT**

There being no further business, the meeting was adjourned at 4 p.m.







